

# **Initial Results and Evaluation Design for the SSA Medicare Part B Buy-in Demonstration**

*Preliminary Report*

Prepared for  
**Social Security Administration**

Prepared by

**The Lewin Group**

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## ACRONYMS AND ABBREVIATIONS

AAPCC	Adjusted Average Per Capita Cost
AARP	American Association of Retired Persons
BIC	Beneficiary Identification Code
CHIP	Children's Health Insurance Program
CR	Claims Representative
DHHS	Department of Health and Human Services
DID	Difference in Difference (analysis)
DOB	Date of Birth
DOWR	District Office Workload Report
DPA	State Department of Public Assistance
DRC	Delayed Retirement Credit
DSU	Direct Service Unit (Social Security Administration, Baltimore, Maryland)
HCFA	Health Care Financing Administration
HIC	Health Insurance Claim
MBP	Monthly Benefit Payable
MBR	Master Beneficiary Record (data)
MEC	MassHealth Enrollment Center
MIS	Management Information System
MSA	Metropolitan Statistical Area
NA	Not Available
PIA	Primary Insurance Amount
QC	Quality Control
QDWI	Qualified Disabled and Working Individual
QI-1	Qualified Individual 1
QI-2	Qualified Individual 2
QMB	Qualified Medicare Beneficiary
PBMO	Part B Medicare Only
P/E	Post Entitlement
RFP	Request for Proposal
SHINE	Serving Health Information Needs of Elders (program)
SLMB	Specified Low-Income Beneficiary
SR	Service Representative
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
TANF	Temporary Assistance for Needy Families



## **EXECUTIVE SUMMARY**

The Medicare Part B Buy-in Demonstration, conducted by the Social Security Administration (SSA), tested four models that attempted to increase participation in the Medicare Part B Buy-in program. This state-administered program uses Medicaid funds to pay Part B premiums and possibly Medicare co-payments and deductibles for low-income beneficiaries. The initial demonstration, which began in March 1999 and concluded in December 1999, targeted Medicare beneficiaries in selected communities in seven states who might be eligible for Buy-in benefits but are not currently receiving them. SSA subsequently expanded the demonstration to include two additional models.

SSA contracted with The Lewin Group to evaluate the demonstration. This is the first of three reports related to the initial demonstration that describes the initial implementation of the demonstration in seven states, presents descriptive analyses of individuals targeted for the program, and discusses future plans for assessing the effectiveness of the models. The second report will provide an update on the demonstration's implementation, along with additional quantitative analysis for the targeted population in the demonstration sites. The third and final report will analyze the impact and effectiveness of the demonstration as well as provide a cost analysis. Supplemental reports will address the results of the additional models.

### **I. OVERVIEW OF THE MEDICARE PART B BUY-IN PROGRAM**

The Medicare Catastrophic Coverage Act of 1988 mandated that, starting in 1989, state Medicaid programs share in the health care costs of low-income Medicare beneficiaries, a group including individuals age 65 or older and certain persons with disabilities. Beneficiaries receive different levels of benefits depending on their income and resources. Specifically, the Qualified Medicare Beneficiary (QMB) program uses Medicaid funds to pay the Part B premiums, Part A and Part B deductibles, and co-payments for Medicare beneficiaries living at or below the poverty guideline. Beneficiaries with incomes between 100 percent and 120 percent of the poverty guideline can participate in the Specified Low-Income Medicare Beneficiary (SLMB) program, which uses Medicaid funds to pay the Part B premium. Beneficiaries with incomes between 120 and 135 percent of the poverty guideline can participate in the Qualifying Individual (QI-1) Program, which pays the Part B premium for beneficiaries. Unlike QMB and SLMB benefits, the QI-1 program is not an entitlement but is funded from a federal block grant to the states; qualified applicants are approved on a first come–first served basis. All three programs limit resources to twice the Supplemental Security Income (SSI) resource limit.<sup>1</sup>

Historically, participation in the Buy-in program has been low. One study estimated that between 3.3 million and 3.9 million of low-income senior citizens and disabled individuals eligible for QMB and SLMB benefits did not receive them in 1998. This results in a participation rate of less than 60 percent. The same study estimated that another 1.6 million individuals potentially are eligible for QI-1 benefits but are not receiving them.<sup>2</sup>

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<sup>1</sup> Some states deviate from the federal resource limits (\$6,000 and \$4,000 for married couples and single beneficiaries, respectively). For example, Florida allows an extra \$1,000 in resources for single individuals.

<sup>2</sup> Families USA (1998). *Shortchanged: Billions Withheld from Medicare Beneficiaries*. Washington, D.C.

## II. BUY-IN DEMONSTRATION

In response to these low participation rates, Congress directed SSA to conduct a research demonstration for determining how best to increase participation.<sup>3</sup> Several possible reasons have been offered for the low participation, including 1) a lack of knowledge about the program; 2) a lack of familiarity with the local Medicaid agency; 3) the additional time and transportation required to travel to a different location; 4) the welfare stigma associated with Medicaid benefits; and 5) the complexity of the Medicaid application form. The four models, implemented at sites identified in *Exhibit ES.1* strove to reduce some of these barriers.

- **Screening Model.** This model tested the use of SSA as a “filter” for potential Buy-in eligibility. In selected communities, letters were sent to Medicare beneficiaries while brochures, posters, and other outreach methods directed potential Buy-in participants to call a special toll-free number at SSA’s Direct Service Unit (DSU)<sup>4</sup> or to visit their local welfare, social services, medical assistance, or SSA office. Individuals who called the DSU or visited the local SSA office were “screened” by a SSA worker using a PC-based program. If based on the screening the beneficiary appeared eligible for QMB, SLMB, or QI-1, SSA attempted to set up an appointment for an application with the local Medicaid agency. This model was tested in two Pennsylvania sites (Carlisle and Lebanon).
- **Co-location Model.** This model tested the use of an SSA office, rather than a state Medicaid agency, for Buy-in eligibility application intake. The DSU or local SSA field office first screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA staff set up an application appointment with a state Medicaid agency employee at the local SSA field office. The co-location model was implemented in Oklahoma (Muskogee and Oklahoma City) and Pennsylvania (West Chester and Uniontown).
- **Application Model.** This model tested application completion by SSA employees rather than Medicaid agency employees. Again, the DSU or local SSA office screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA set up an application appointment with an SSA employee at the local SSA office. The SSA employee then completed the state’s application form for Buy-in, accepted and copied evidence provided at the time of the application, and forwarded the completed application form and evidence to the Medicaid agency for further development (if necessary) and eligibility determination. The application model was implemented in Texas (Corpus Christi), Florida (Orlando and Miami), Kentucky (Lexington), and Indiana (Evansville).
- **Widow(er)s Model.** This model tested an intervention designed to increase enrollment of widow(er)s who might be newly eligible. The intent of this model was not to reach out to beneficiaries through special SSA mailings or publicity about the Medicare Buy-in programs. Instead, beneficiaries were to be screened for potential Buy-in eligibility when they contacted a designated SSA office to report the death of a spouse. Widow(er)s who appeared to meet the Medicare Buy-in entitlement criteria based on Title II income (Social Security retirement

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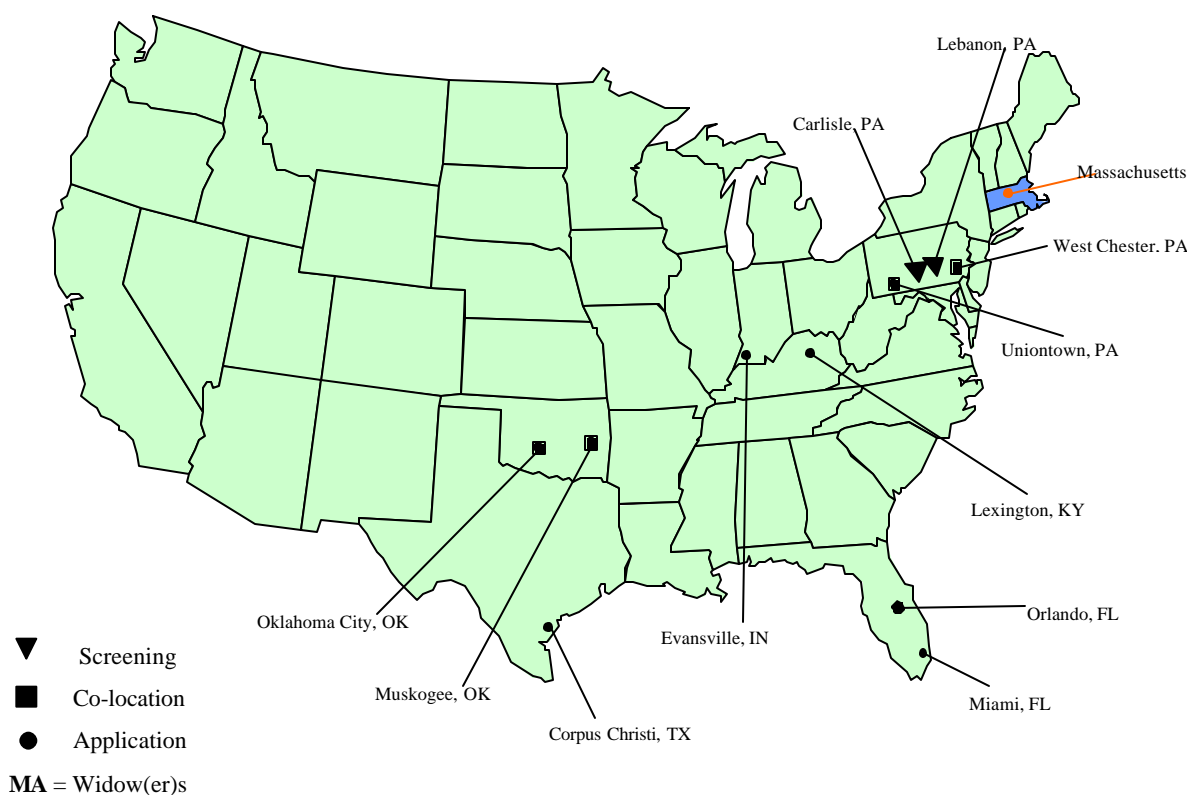
<sup>3</sup> PL 105-277; October 21, 1998.

<sup>4</sup> This number is different from SSA’s nationwide 800 number.

benefits) were screened. The widow(er)s model was implemented in the entire State of Massachusetts.

### Exhibit ES.1

#### SSA Offices (Demonstration Sites)



The first three demonstration models built on each other, with each model designed to remove additional obstacles from the application process. The screening model aimed to increase knowledge about the program; the co-location model reduced problems associated with the separate location of the Medicaid agency (the lack of familiarity and the time and transportation requirements); and the application model aimed to reduce the welfare stigma associated with receiving Medicaid benefits.

SSA originally planned to implement only the first three models but expanded the demonstration to include Medicare beneficiaries whose economic situation might have changed after the death of a spouse. Widow(er)s rely to a greater extent than do couples on their Social Security benefits.<sup>5</sup> Another reason for implementing the widow(er)s model was to ascertain whether SSA

<sup>5</sup> SSA statistics reveal that 40 percent of non-married women (a group that includes widows) rely on Social Security for 90 percent of their income in comparison with only 18 percent of married couples. Nearly 25 percent of non-married women rely on Social Security as their sole source of income. (Statements on Introduced Bills and Joint Resolutions [Senate–September 29, 1998].)

could identify a substantial number of potential Buy-in eligibles in the course of conducting routine business, without the extensive outreach efforts of the first three models.

The widow(er)s model has gone through several changes since the beginning of the demonstration. Section VI of this Executive Summary discusses these in more detail.

### **III. DEMONSTRATION START-UP**

SSA set the broad parameters for how the models would be implemented, but within this framework, the SSA field offices and state Medicaid agencies made local decisions regarding staffing, training, and outreach.

#### **A. Demonstration Staffing**

Each field office made its own decisions regarding how it would staff the demonstration. In general, SSA field offices trained all staff to use the screening program and assigned service representatives (SR) to the screening, while claims representatives (CR) served as backups. In all application sites except Miami, Florida, Title XVI CRs were assigned application intake responsibilities. These staff take SSI applications and, thus, are more experienced with taking applications for means-tested programs. In Miami, Title II CRs were assigned these responsibilities.

#### **B. Staff Training**

At the beginning of the demonstration, the screeners at the DSU went through extensive training for three days. In contrast, screeners at the SSA field offices had only one to two hours of training, which was uniformly judged as adequate. Screeners at the DSU had to become familiar with the application scheduling practices of all demonstration sites whereas screeners at the field office could focus on understanding the process for their demonstration site. All screeners found the screening tool user friendly.

In application model sites, application staff were trained on Buy-in application intake by the state Medicaid agency. The Medicaid agency provided training materials to the SSA field offices as well as on-site training. Training lasted between one and one-half to two hours, with the exception of that in Orlando, Florida, which lasted 40 minutes. CRs responsible for taking the Buy-in applications were familiar with the intake of applications and felt the training was adequate.

Because SSA staff were not responsible for adjudicating the Buy-in applications, they were not trained on the adjudication process. As a result, the SSA application staff were not as well informed about the requirements as they could have been. This caused some problems in adjudication for the local Medicaid agency, especially when requirements for the state were not as stringent as the adjudication requirements for SSA.

#### **C. Outreach Efforts**

In the screening, co-location, and application models, the success of the demonstration was contingent on Medicare beneficiaries' learning about the program and contacting SSA. The

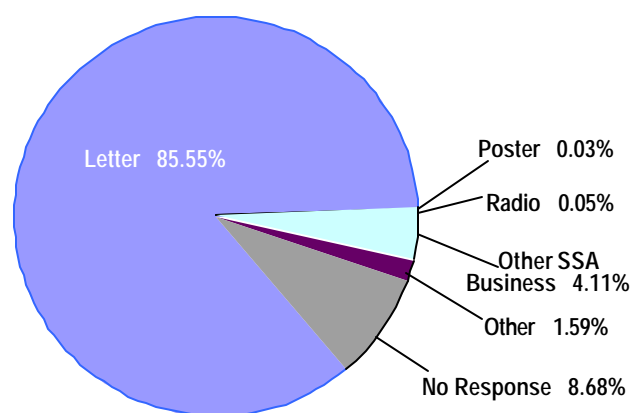
outreach efforts involved sending letters to single Medicare Part A beneficiaries in the demonstration areas whose monthly Title II Social Security benefits were less than \$947 and identified married beneficiaries whose combined income was less than \$1,265.<sup>6</sup>

A total of 239,048 letters were sent to individuals living in demonstration areas staggered in nine separate batches.<sup>7</sup> By the third mailing, the volume of letters being sent resulted in an overwhelming increase in the volume of telephone calls to the DSU as well as calls and visits to the SSA field offices. SSA added three additional mailing dates to the original schedule to spread the remaining letters across more mailings, producing a more manageable number of calls to the DSU.

In addition to the letters, SSA made posters, brochures, public service announcements, and articles for print media available to the field offices. SSA field offices engaged in varying degrees of outreach, including putting up posters at the post office, the Office of Aging, senior citizen centers, and the local Medicaid agency; holding question and answer radio shows; and, in field offices serving large Hispanic populations, engaging in outreach specifically targeting Hispanic beneficiaries.

In all sites where SSA used targeted letters to reach potential clients, the letters were considered by far to be the most effective form of outreach. The screening data confirm that a large majority of those screened heard about the program through the SSA outreach letter. Approximately 86 percent reported that the letter from SSA was the source through which they had heard about their potential eligibility (see *Exhibit ES.2* below).

**Exhibit ES.2**  
**Method in Which Screened Individuals Learned**  
**about the Buy-in Program**



Source: The Lewin Group tabulations of screening data.

<sup>6</sup> SSA administrative data do not readily link the records for the members of married couples. Letters were sent also to individuals who had received at least 24 months of disability insurance and individuals who had attained the age of 64 years and 11 months, if their Title II benefits fell below the limits.

<sup>7</sup> This does not include 62 letters inadvertently sent to individuals living in one zip code in Uniontown, Pennsylvania, that the Uniontown SSA field office does not serve.

## IV. SCREENING PROCESS

Screening typically took fewer than 10 minutes, with few problems. One universal complaint raised by screening staff during interviews was that the screening program did not allow them to back up to a previous screen in the event that the client remembered additional income or resources after the relevant screen had passed. If SSA implemented one of the three models nationally, this systems limitation could be corrected easily in the software program.

### A. Response to Outreach Letters

Of the 239,048 letters mailed to Medicare beneficiaries, the DSU and local SSA field offices screened 15,656 individuals who lived in the demonstration area as of December 31, 1999; this amounts to a response rate of 6.3 percent (see *Exhibit ES.3* below).<sup>8</sup>

#### Exhibit ES.3

#### Letter Recipients, Individuals Screened, and Potential Eligibles, by Model

Site	Number Sent Letter	Total Number Screened	Percent Screened
Screening Model	28,161	1,464	5.2%
Co-location Model	85,885	4,324	5.0%
Application Model	125,002	9,308	7.4%
Massachusetts	NA	560	NA
<b>TOTAL including MA if applicable</b>	<b>239,048</b>	<b>15,656</b>	<b>6.3%</b>

Source: The Lewin Group tabulations of matched screener and Master Beneficiary Record data.

Several possible explanations exist as to why more letter recipients did not respond. First, the letter to the beneficiary explains who is eligible; many non-responders might have correctly determined that their income or resources would exceed the allowable limits. Second, one field office worker noted that senior citizens are sent a barrage of information regarding health insurance and Medicare and might have ignored the letter. Finally, a small number of people (1.3 percent) never received the letter, perhaps having moved or died.

Interestingly, application sites had higher response rates than the screening and co-location sites had. Because letter outreach efforts remained the same for the three models, site-specific factors presumably explain these differences in rates. Specifically, the beneficiaries living in application sites received lower average Social Security benefits than did beneficiaries living in screening and co-location sites, implying they were more likely to realize they were eligible and were more in need of the benefits. In addition, it is possible that outreach efforts targeted at the Hispanic community might have increased the response. Miami, Florida; Corpus Christi, Texas; and Orlando, Florida, have relatively large Hispanic populations and had the highest response rates.

<sup>8</sup> A total of 16,028 people were screened by either the DSU or a local SSA field office as of December 31, 1999. Of those screened, 372, or 23 percent, were determined to have a zip code outside of the designated demonstration areas.

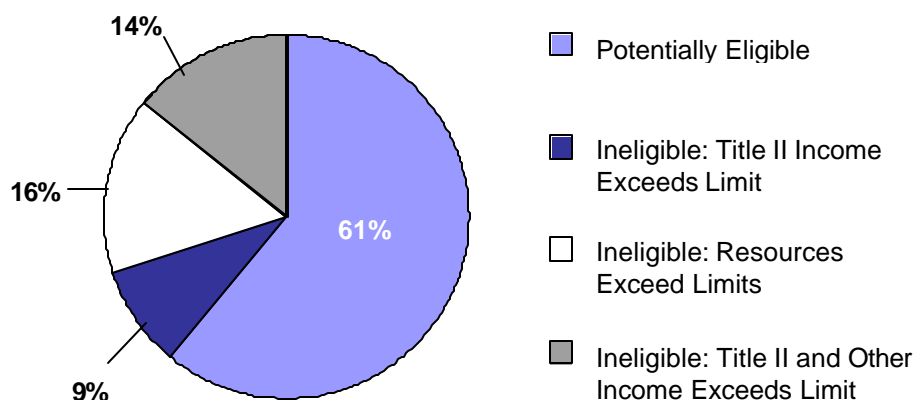
A hazard analysis will be conducted and will be included in a future report to capture which factors most affected the response to mailings.

The fact that many recent widow(er)s do not contact the field office after the death of a spouse accounts in part for the low volume of screenings conducted in Massachusetts; in many cases, the funeral director notifies the field office and benefits are discontinued or adjusted. This demonstration model depended on field office staff to identify the appropriate clients who came in for other reasons. Because of the low volume, the process never became routine, so staff might have forgotten to identify potentially eligible clients.

## **B. Outcomes from the Screener Data**

The list below summarizes the characteristics of those screened and the potential eligibility outcomes:

- The majority of those screened were female (69 percent) and nearly 30 percent of the individuals screened reported that they were married.
- As shown in *Exhibit ES.4*, most beneficiaries screened were determined to be potentially eligible (61 percent). Of those deemed potentially ineligible: 9 percent were potentially ineligible because their Title II income exceeded the income limits, 16 percent because their resources exceeded the limits, and 14 percent because their Title II *and other income* exceeded the income limits (that is, their Title II income was under the limits, but, combined with other household income, their income exceeded the limits).
- Additional analysis found that a much larger proportion of married couples had Title II income that exceeded the limits than single claimants – 26.2 percent of couples compared with just 1.7 percent of single claimants. Couples sent outreach letters were more likely to exceed the income criteria than single claimants were because the Master Beneficiary Record (MBR) income data used to identify possible eligibles understated income for some couples. Specifically, if each spouse receives benefits based on his or her earnings, rather than on the higher earner's earnings, the MBR will contain separate records for each spouse. Thus, even if the sum of the two income amounts were to exceed the eligibility limits, each spouse would individually be identified as under the limits.
- Examining eligibility by age, the younger respondents (under age 65) and the oldest (aged 85 and older) were more likely to be screened potentially eligible.

**Exhibit ES.4****Eligibility Status from Screening**

Source: The Lewin Group tabulations of screening data.

## **V. APPLICATION PROCESS**

Although all models except the widow(er)s model used the same basic approach for outreach and screening, the models used different paths to get the beneficiary from screening to the completion of a Buy-in application. The screening and widow(er)s models referred potential eligibles to the state Medicaid agency, the co-location model referred them to the SSA office to meet with a co-located state worker, and the application model referred them to the SSA office to meet with an SSA worker. In addition, state-specific application processes might affect enrollment.

### **A. Required Process for Submitting an Application**

As discussed earlier, states were encouraged to reduce the complexity of the applications to increase enrollment in the Buy-in program. All the states except Oklahoma began using a short form for at least a portion of the demonstration period, which might increase enrollment (Texas had been using a shortened application before the demonstration). In addition, some states (Texas, Massachusetts, and Florida) reduced the level of evidence or verification required, which could also increase participation.

### **B. Scheduling of Application Appointments**

The different models required different kinds of coordination among the SSA field office, state Medicaid agency, and DSU to ensure that clients who were screened potentially eligible completed an official Buy-in application. Such coordination brings with it the possibility for communication problems between offices. For example, the DSU had to link the caller's zip code with the demonstration site and model to determine whether to schedule an appointment on the SSA's electronic scheduling calendar (co-location and application sites) or with the state



Medicaid agency (screening sites). In addition, differences existed in the ways that certain field offices used SSA's scheduling system (e.g., using different categories). As a result, several field offices reported the DSU was not properly scheduling appointments. Avoiding this type of confusion in a nationwide program might require improved training at the DSU or more uniformity in scheduling procedures across field offices.

### **C. Additional Barriers to Completing Applications**

Besides the application form and scheduling issues, other barriers might prevent the beneficiary from applying for benefits, complicating the administrative picture for the agencies involved. These include the following:

- **Scheduling difficulties and unavailability of application appointments.** Most demonstration sites reported a large volume of application appointments following mailings, resulting in appointment backlogs of up to one month. It is possible that clients forced to wait a considerable period of time between screening and application might be less likely to actually apply than those whose applications are taken immediately or soon after they are screened.
- **Clients' feelings about the state Medicaid agency.** Clients' attitudes about welfare and the agency that administers programs they consider welfare can strongly affect their decision to seek benefits from that agency. Interviews with SSA field office and state Medicaid agency staff provided substantial anecdotal evidence to support the existence of a negative view of welfare benefits in at least some communities. These feelings seemed strongest in the screening model sites.
- **Interaction of state application requirements and other barriers to applying for Buy-in benefits.** Certain combinations of state application requirements might create particular problems or opportunities for specific model approaches. For example, if it is true that clients, for whatever reason, have misgivings about going to the state Medicaid agency to apply for Buy-in benefits, the screening model will work less well should clients be required to visit the state Medicaid agency in person. However, if a state developed a simple short-form application that can be filled out without supervision or assistance and mailed into the state Medicaid agency, the screening model might work well, even in the face of negative feelings about welfare or unfamiliarity with the state Medicaid agency.

### **D. Application Submission Process at the Application Model Sites**

Because the application model involved the use of a non-state worker to take an application for a state program, it had the greatest potential to create problems for the state's adjudication process. Clear communication is probably most critical in the application model sites because the SSA field office must understand what the state needs to efficiently adjudicate the application. Application model sites reported good relationships between the field office and the state Medicaid agency and felt that the demonstration brought the field office and the state Medicaid agency closer together. Demonstration staff felt that the application model worked well and ran smoothly, although the sites experienced some early missteps as the SSA field office learned how to meet the state's requirements.

## **VI. ISSUES ASSOCIATED WITH THE WIDOW(ER)S MODEL**

The widow(er)s model used in Massachusetts underwent several modifications over the course of the demonstration, affecting the outreach, the scheduling of appointments, and the application process.

In mid-July 1999, in response to the low volume of screenings being generated by the demonstration, SSA changed its policy and began reviewing death reports from funeral directors as leads and contacting appropriate clients for screening. This practice diverged from the original concept of identifying prospective Buy-in candidates from among widowed clients who contacted the SSA field office for other reasons (most likely to change benefit status following death of a spouse). In mid-September 1999, the process was further formalized when field offices were instructed to provide outreach letters to the leads identified through the funeral director death reports.

In addition, field offices were originally told to set up telephone appointments with MassHealth Enrollment Centers (MEC), the state Medicaid agency, if clients had questions regarding the application. MEC does not conduct in-person interviews because there are only four Center locations in the state, making it difficult for many clients to access them. Thus, the field offices were to send or give the screening letter and application packet to the client, and the client was to mail the application to MEC. MEC staff later indicated that they preferred that the field offices stop setting up appointments with MEC altogether and instead instruct the client to contact them any time during business hours for questions about the application. This approach was later made the standard procedure for the widow(er)s model throughout Massachusetts.

Finally, at the outset of the demonstration, the state supplied the field offices a relatively new shortened form to use in the demonstration specifically for SLMB and QI-1 benefits (thus, the form covers premiums but not co-payments or deductibles). To access QMB benefits, the state requires that the standard long Medicaid application be used. However, the state did not provide the standard long form to the field offices. This process created concern that the demonstration process put clients in a disadvantageous position, which led to procedural changes later. In mid-September 1999, the state sent letters to new SLMB and QI-1 enrollees informing them of the additional benefits for which they might be eligible. For the demonstration, SSA and the state eventually agreed that these long forms would be distributed to all field offices. Procedures for QMB enrollment became a standard part of the widow(er)s model in mid-September.

It is still not known whether these modifications led to greater levels of enrollment. Future analyses will be conducted to examine whether increases in enrollment occurred after each change as a result of the new policy. Some field offices noted that the lack of volume and several changes during the course of the demonstration might have had a detrimental effect on their ability to identify widow(er)s for the demonstration.

## **VII. SYNTHESIS AND LESSONS LEARNED IN THE DEMONSTRATION**

To prepare for this report, The Lewin Group conducted extensive interviews with SSA and state staff and reviewed SSA site visit reports. The information collected from this field research indicates that the four demonstration models were implemented as intended. As was expected,

each site adapted the model to fit the SSA field office and state Medicaid agency's staffing levels and organizational structure. However, these adaptations should not greatly influence the impact of each model on enrollment.

The experience of SSA and state agency staff implementing and operating the four demonstration models provides several lessons for possible expansions to the existing demonstration or national implementation. The key lessons include the need for clear communication among all parties involved in the demonstration; a well-defined liaison role to resolve implementation problems efficiently; accountability on the part of the central office and field offices participating in the demonstration; adequate training; local flexibility in implementation strategy; and commitment from major players.

## **VIII. ANALYSIS PLAN FOR THE INTERIM AND FINAL REPORTS**

### **A. Research Questions**

The primary research questions The Lewin Group plans to investigate include the following:

- Are there differences in the response rate to the letters, in the percent screened to be eligible, and in the application rate or the enrollment rate by site or by model?
- Do individuals with certain characteristics have higher screening rates?
- Do demonstration sites have a larger increase in enrollment from the pre- to post-period than the comparison areas?

These research questions involve a number of quantitative analyses, the results of which will be interpreted in light of the process portion of the evaluation.

### **B. Interim Report**

The interim report will build on this preliminary report and complete the process evaluation by including several additional quantitative analyses to indicate among which groups the outreach was more successful and to inform staffing and logistics for potential future efforts. Those include a participant/non-participant analysis to determine which characteristics make a beneficiary more likely to respond to outreach efforts and file an application for the Buy-in program; an analysis of undelivered letters to determine if beneficiary characteristics influenced whether letters were returned, in particular direct deposit status; a no-show rate analysis to explore the potential effect of welfare stigma, lack of transportation, or unfamiliarity with the welfare office on enrollment in the Buy-in program<sup>9</sup>; an adjudication analysis to determine which characteristics make a beneficiary more likely to enroll in the Buy-in program; and a time-

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<sup>9</sup> The no-show analysis will quantify the number of beneficiaries who were screened potentially eligible and had an appointment scheduled but did not make their appointment (i.e., they cancelled or simply did not show up). Comparing no-show rates by model might be suggestive of potential reasons for low participation in the Buy-in program.

flow analysis to determine the length of time between steps in the screening and application processes and if it differs based on a respondent's characteristics.

### **C. Final Report**

The final report will focus on the impact and cost analyses. For three of the four models, we will conduct a combined pre-post and comparison group non-experimental design for the outcome evaluation relying on the difference between the change in enrollment from the pre- to post-periods for the demonstration sites and the comparison areas to identify the net impact of the demonstration on Buy-in enrollment. This approach is called a difference in difference (DID) analysis. For the widow(er)s model, we must rely on a pre-post analyses with no comparison group because Massachusetts was the only site and the state chose to implement it statewide. Given dramatic differences in the manner in which Medicaid process applications, an appropriate comparison site for Massachusetts to pursue the DID approach could not be identified.

The impact analysis will use two outcome measures: application and enrollment. Filing of applications is a measure of the success of the outreach efforts. Enrollment in the Buy-in program is a measure of the success of the demonstration. Most participating states have made enrollment data available through agreements with SSA; however, few of the states can provide application data for both the pre- and post-periods.

The study populations will include Medicare beneficiaries living within the demonstration or comparison areas, whose Title II benefits are less than 135 percent of the poverty guideline and who currently receive no Buy-in benefits. The study population in the demonstration areas received a letter, whereas the study population in the comparison areas did not. Based on our site visits and conversations with key staff at each site, we have concluded that, despite some variations by site, the demonstration models appear to have been implemented consistently enough that the effects of each demonstration model on the outcomes can be assessed jointly across sites for each model and also independently, sample sizes permitting.

We will use the remainder of the state as a comparison area. We have also identified specific comparison areas that are in the same state and have economic and demographic characteristics similar to the demonstration area. In particular, we made sure that comparison and demonstration areas were similar in Metropolitan Statistical Area (MSA) status, percentage in poverty, percentage of population over 65, and racial composition.

The cost analysis will estimate how much it costs the government (federal, state, and local) to generate an additional applicant and an additional enrollee under the four models being tested. The cost analysis will not include the payment of the Part B premium, deductibles, or coinsurance but will focus on the cost associated with increasing enrollment in the Buy-in program. Costs will be divided into state and SSA costs, and an average cost per applicant and per enrollee will be calculated for both the state and SSA.

## **CHAPTER 1: INTRODUCTION**

The Medicare Part B Buy-in Demonstration, conducted by the Social Security Administration (SSA), is testing four models that attempt to increase participation in the Medicare Part B Buy-in program. This state-administered program uses Medicaid funds to pay Part B premiums and possibly Medicare co-payments and deductibles for low-income beneficiaries. The demonstration, which began in March 1999 and concluded in December 1999, targeted Medicare beneficiaries in selected communities in seven states who might be eligible for Buy-in benefits but are not currently receiving them. SSA subsequently expanded the demonstration to include two additional models.

SSA contracted with The Lewin Group to evaluate the demonstration. This is the first of three reports related to the initial demonstration that describes the initial implementation of the demonstration in eleven communities and the State of Massachusetts, presents descriptive analyses of the individuals targeted for the program, and discusses the future plans for assessing the effectiveness of the models. The second report will provide an update on the demonstration's implementation along with additional quantitative analyses for the targeted population within the demonstration sites. The third, and final, report will analyze the impact and effectiveness of the demonstration as well as provide a cost analysis. Supplemental reports will address the results of the additional models.

This chapter presents an overview of the Medicare Part B Buy-in program, describes the purpose of the demonstration and each model, and discusses the selection of the demonstration sites. Chapter 2 describes the data methods and sources for the preliminary evaluation. Chapter 3 focuses on the start-up of the demonstration, including Buy-in practices before the demonstration, each model's intended sequence, office staffing, and staff training. Chapter 4 discusses outreach methods used by the sites, response rates, and staff suggestions for improvement. Chapter 5 provides an overview of the screening process and presents process related outcomes and characteristics of those screened. Chapter 6 outlines the application and adjudication process. Chapter 7 synthesizes the demonstration process, focusing on the lessons learned. Finally, Chapter 8 discusses the analysis plans for the second and third reports.

### **I. MEDICARE PART B BUY-IN PROGRAM: AN OVERVIEW**

Nearly all persons age 65 or older, and certain persons with disabilities, are entitled to Medicare coverage. However, Medicare does not cover all health care costs, including Medicare's Part B premium, co-insurance and deductibles, and most outpatient prescribed medicines and long-term care. Consequently, low-income Medicare beneficiaries face greater difficulties paying for health care services than do other Medicare beneficiaries. One study found that persons age 65 years and older living on the margin of poverty (defined as having income between 100 and 125 percent of the federal poverty guideline) have health care costs that consume nearly one-quarter of their annual income.<sup>10</sup>

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<sup>10</sup> Gross, D. and L. Alecxih, et al. (1997). Out-of-Pocket Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections. AARP Public Policy Institute Report #9705. Washington, D.C.

The Medicare Catastrophic Coverage Act of 1988 mandated that, beginning January 1989, state Medicaid programs share in health care costs of low-income Medicare beneficiaries. Specifically, the Qualified Medicare Beneficiary (QMB) program uses Medicaid funds to pay the Part B premiums, Part A and Part B deductibles, and co-payments for Medicare beneficiaries living at or below the poverty guideline. Beneficiaries with incomes between 100 percent and 120 percent of the poverty guideline can participate in the Specified Low-Income Medicare Beneficiary (SLMB) program, which uses Medicaid funds to pay the Part B premium. Beneficiaries with incomes between 120 and 135 percent of the poverty guideline can participate in the Qualifying Individual (QI-1) Program, which pays the Part B premium for beneficiaries. Unlike QMB and SLMB benefits, the QI-1 program is not an entitlement but is funded from a federal block grant to the states; qualified applicants are approved on a first come–first served basis. All three programs limit resources to twice the Supplemental Security Income (SSI) resource limit.<sup>11</sup> **Exhibit 1.1** lists the 1999 income and resource limits for the three Buy-in programs included in the demonstration.

**Exhibit 1.1**  
**Medicare Buy-in Income and Resource Limits, 1999**

Program	Income Limits <sup>a</sup>	Resource Limits <sup>b</sup>	Benefits <sup>c</sup>
QMB	\$707 Individual or \$942 Couple	\$4,000 Individual or \$6,000 Couple	Premiums, deductibles, and coinsurance
SLMB	\$844 Individual or \$1,126 Couple	\$4,000 Individual or \$6,000 Couple	Medicare Part B premiums
QI-1	\$947 Individual or \$1,265 Couple	\$4,000 Individual or \$6,000 Couple	Medicare Part B premiums

Note: Applies to all states except Alaska and Hawaii.

<sup>a/</sup> Income includes earnings, Social Security benefits, pensions, wages, interest payments, dividends on stocks and bonds, and other income received regularly. They are based on percentages of the Department of Health and Human Services (DHHS) poverty guidelines and include the \$20 non-earnings disregard. QMB is 100 percent, SLMB is 120 percent and QI-1 is 135 percent of the poverty guideline. Couple limits are for married units where both husband and wife qualify (i.e., receive Medicare Part A).

<sup>b/</sup> Resources include bank accounts, stocks, bonds, and the combined face value of the individual's life insurance policy, if it is \$1,500 or more. The value of the individual's home, one automobile, burial plots, home furnishings, and personal jewelry are not included. Florida allows an extra \$1,000 in resources for individuals.

<sup>c/</sup> The monthly Medicare Part B premium was \$45.50 per month in 1999.

It is important to note that three other Buy-in programs assist Medicare beneficiaries, although these programs are not within the scope of this demonstration. The Qualified Disabled and Working Individuals (QDWI) program assists individuals with incomes at or below 200 percent of the federal poverty guideline and resources that do not exceed twice the limit for SSI eligibility, who lost their Medicare Part A benefits because they returned to work. Medicaid pays their Medicare Part A premiums only. Qualifying Individuals 2 (QI-2) program benefits are available to individuals with incomes between 135 and 175 percent of the poverty guideline, subject to availability of funds. Medicaid pays a portion of QI-2 beneficiaries' Part B premiums,

<sup>11</sup> Some states deviate from the federal resource limits (\$6,000 and \$4,000 for married couples and single beneficiaries, respectively). For example, Florida allows an extra \$1,000 in resources for individuals.

which in calendar year 1999 amounted to \$2.23 per month. Finally, the Medicaid Only Dual Eligibles benefits are available to individuals who are not eligible as a QMB, SLMB, QDWI, QI-1, or QI-2 participant but who qualify for full Medicaid benefits because of their high health care costs. These individuals spend down (i.e., have incomes minus out-of-pocket health care expenses that are below defined income limits and have resources less than the limits) to qualify for these benefits. Because these three programs are not part of the demonstration, the remainder of the report focuses only on the QMB, SLMB, and QI-1 programs.

## **II. PURPOSE OF THE DEMONSTRATION**

Historically, participation in the Buy-in program has been low. One study estimated that between 3.3 million and 3.9 million of low-income senior citizens and disabled individuals eligible for QMB benefits and SLMB did not receive them in 1998. This results in a participation rate of less than 60 percent. The same study estimated that another 1.6 million individuals potentially are eligible for QI-1 benefits and are not receiving them.<sup>12</sup> Other studies have found similarly low participation rates.<sup>13</sup>

In response to these low participation rates, Congress directed SSA to conduct a research demonstration to determine how best to increase participation.<sup>14</sup> This demonstration tested four different models designed to eliminate barriers to participation. This preliminary evaluation assesses the issues and problems that arose in implementing each model of the demonstration while later analyses will estimate the costs and the effectiveness of the models.

### **A. Possible Reasons for Low Participation**

Several studies have sought to explain the low participation rate in the Buy-in program.

Possible reasons include the following:<sup>15</sup>

- **Lack of knowledge about the program.** Beneficiaries might not be aware of the program's existence or eligibility requirements.

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<sup>12</sup> Families USA (1998). *Shortchanged: Billions Withheld from Medicare Beneficiaries*. Washington, D.C.

<sup>13</sup> For example, one study found that participation in the QMB program in 1993 was 58 percent of people age 65 and over eligible for QMB (Families USA [1993]. *The Medicare Buy-in: A Promise Unfulfilled*. Washington D.C.). Another study updated this estimate to 41 percent in 1994 (Neuman, P., M. Bernardin, E. Bayer, and W. Evans [1994]. *Identifying Barriers to Elderly Participation in the Qualified Medicare Beneficiary Program*. Washington, D.C.). An Urban Institute study calculated a participation rate of 63 percent of QMB eligibles and 10 percent of SLMB eligibles in 1996 (Moon, M., C. Kuntz, and L. Pounder [1996]. *Protecting Low-Income Medicare Beneficiaries*. Washington, D.C.). In a more recent Urban Institute study, the estimates increased to 78 percent of eligible QMBs and 16 percent of eligible SLMBs. However, these figures are based on all Medicare beneficiaries, including the institutionalized, so they are not directly comparable to the earlier studies (Moon, M. N., Brennan, and M. Segal [1998]. *Options for Aiding Low-Income Medicare Beneficiaries*. Washington, D.C.).

<sup>14</sup> PL 105-277; October 21, 1998.

<sup>15</sup> Rosenbach and Lamphere (1999); Families USA (1998); Moon, et al. (1998); and Nemore, P. (1997). *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries*. Washington, D.C.

- **Separate, often unfamiliar, location for filing application.** Buy-in applications are filed at the state welfare agency, whereas Medicare enrollment is typically automatic, based on Social Security entitlement. The separate trip to the welfare agency or unfamiliarity with the state welfare system might discourage beneficiaries from applying for benefits.
- **Welfare stigma.** Some individuals associate Medicaid with welfare. This stigma might discourage beneficiaries from applying for Buy-in benefits.
- **Complexity of application form.** Many state Medicaid applications are lengthy and require extensive documentation of income and assets. The Department of Health and Human Services (DHHS) has developed a shorter, simplified application form that is available to states, although only a few have used it.

In addition, there might be financial disincentives on the part of state governments to publicize the program. Medicare is a federal program, while QMB and SLMB are funded jointly by the states and the federal government. Higher participation in the Medicare Buy-in programs would increase state expenses.

Low participation in the Buy-in program might result from a combination of reasons. In addition, the perceived benefits of program participation might not be large enough to encourage individuals to follow through with the application, especially if this involves driving or finding transportation to a new location, feeling stigmatized by going to the welfare office, or filling out a complex application form.

Finally, participation rates from the various studies could be inaccurate. All of the estimates combine different data sources and must make various adjustments because no single data source has the necessary participation information and verified income and financial resource information. In particular, survey data used as the denominator for most estimates of participation might underestimate income and financial resources, which would inflate the denominator, causing a potential underestimate of the percent participating. However, the primary source of income among low-income Medicare beneficiaries, Social Security, tends to be well reported in survey data.

## **B. Demonstration Models**

SSA developed four models that aimed to remove some barriers to participation: the screening model, the co-location model, the application model, and the widow(er)s model. Each is discussed briefly below and in more detail in Chapter 3.

1. **Screening Model.** This model tested the use of SSA as a filter for potential Buy-in eligibility. In selected communities, letters were sent to Medicare beneficiaries, although brochures, posters, and other outreach methods directed potential Buy-in participants to call a special toll-free number<sup>16</sup> at SSA's Direct Service Unit (DSU) or to visit their local welfare, social services, medical assistance, or Social Security office. An SSA worker, using a PC-based program, screened individuals who called the DSU or visited the local Social Security

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<sup>16</sup> This number is different from SSA's nationwide 800 number.



office. If the beneficiary appeared eligible for QMB, SLMB, or QI-1 based on the screening, SSA attempted to set up an appointment to fill out an application with the local Medicaid agency.

2. **Co-location Model.** This model tested the use of an SSA office, rather than a county Medicaid agency, for Buy-in eligibility application intake. The DSU or local Social Security field office first screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA staff set up an application appointment with a Medicaid agency employee located at the local SSA office.
3. **Application Model.** This model tested application completion by SSA employees rather than by a Medicaid agency employee. Again, the DSU or local Social Security office screened beneficiaries. If the beneficiary appeared eligible based on the screening, SSA set up an application appointment with an SSA employee at the local SSA office. The SSA employee then completed the state's application form for Buy-in, accepted and copied evidence provided at the time of the application, and forwarded the completed application form and evidence to the Medicaid agency for further development (if necessary) and eligibility determination.
4. **Widow(er)s Model.** This model tested an intervention without extraordinary publicity. This model was not meant to reach out to beneficiaries with special SSA mailings or publicity about the Medicare Buy-in programs. Instead, beneficiaries were to be screened for potential Buy-in eligibility when they contacted a designated SSA office to report the death of a spouse. Widow(er)s who appeared to meet the Medicare Buy-in entitlement criteria based on Title II income (Social Security retirement benefits) were screened. Originally, the model planned for SSA field office staff to set up a phone appointment with the local Medicaid agency, and potential Buy-in beneficiaries would file for Buy-in benefits with that agency. This plan changed during the course of the evaluation, as discussed further in Chapter 3.

SSA originally planned to implement only the first three models for the demonstration but expanded the demonstration to include Medicare beneficiaries whose economic situation might have changed because of the death of a spouse. Widow(er)s rely on their Social Security benefits to a greater extent than do couples; SSA statistics reveal that 40 percent of non-married women (a group that includes widows) rely on Social Security for 90 percent of their income in comparison with only 18 percent of married couples. Nearly one-quarter of non-married women rely on Social Security as their sole source of income.<sup>17</sup> Another reason for implementing the widow(er)s model was to ascertain whether SSA could identify a substantial number of potential Buy-in eligibles in the course of conducting routine business.

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<sup>17</sup> Statements on Introduced Bills and Joint Resolutions (Senate–September 29, 1998).

**Exhibit 1.2**  
**Addressing Barriers to Participation**

<b>Barrier</b>	<b>Screening Model</b>	<b>Co-location Model</b>	<b>Application Model</b>	<b>Widow(er)s Model</b>
<b>Lack of knowledge about the program</b>	Outreach included letters, posters, brochures, and publicity.	Outreach included letters, posters, brochures, and publicity.	Outreach included letters, posters, brochures, and publicity.	Recent widow(er)s who called in to report the death of a spouse were informed of the benefits. In addition some field offices initially reviewed forms submitted by funeral directors informing the office of deaths. Review of the forms was formalized as part of the demonstration in September.
<b>Separate location for filing application</b>	No change.	Application could be completed at the SSA office by Medicaid staff.	Application could be completed at the SSA office by SSA staff.	No change.
<b>Welfare stigma</b>	No change.	Possibly completing application at SSA office reduced stigma, although applicant still met with a state Medicaid worker.	Completing application at SSA office with SSA worker may have eliminated or greatly reduced welfare stigma.	No change.
<b>Complexity of application form</b>	State determined form.	State determined form.	State determined form.	State determined form.
<b>Financial disincentives of state government</b>	SSA was responsible for referrals; state was responsible for follow-up.	SSA was responsible for referrals; state was responsible for follow-up.	SSA could more directly increase the number of applications.	SSA was responsible for referrals; state was responsible for follow-up.

*Exhibit 1.2* lists the extent to which each model addressed the barriers identified in Section I.A. All models relied on the state Medicaid agencies to adjudicate claims. As this exhibit shows, the application model aimed to do more than the other three to reduce barriers to application. However, this does not mean the application model will be more successful than the other models in increasing participation. Having a Medicaid worker who is likely to be more familiar with the application process conduct the intake, as is the case under the screening and co-location models, might have led to a greater percentage of applications being approved.

While SSA encouraged states to use a less complex application form, the states made the determination of which form(s) to use and whether to use a different application process in the demonstration community. Chapters 3 and 6 outline which states chose to use shorter forms and for which programs.

### III. DEMONSTRATION SITES

Eleven sites in six states plus the entire State of Massachusetts were selected to participate in the demonstration. This section describes site selection and site characteristics.

#### A. State Application Process

On November 18, 1998, SSA published an announcement about the demonstration in the Federal Register inviting states to submit expressions of interest. States that responded were contacted in January 1999. The original plan was to implement each of the screening, co-location, and application models in five communities, for a total of 15 participating communities. The widow(er)s model would be tested in at least one major urban area. As illustrated in *Exhibit 1.3*, fewer than 15 communities participated while the widow(er)s model was tested in the entire State of Massachusetts.

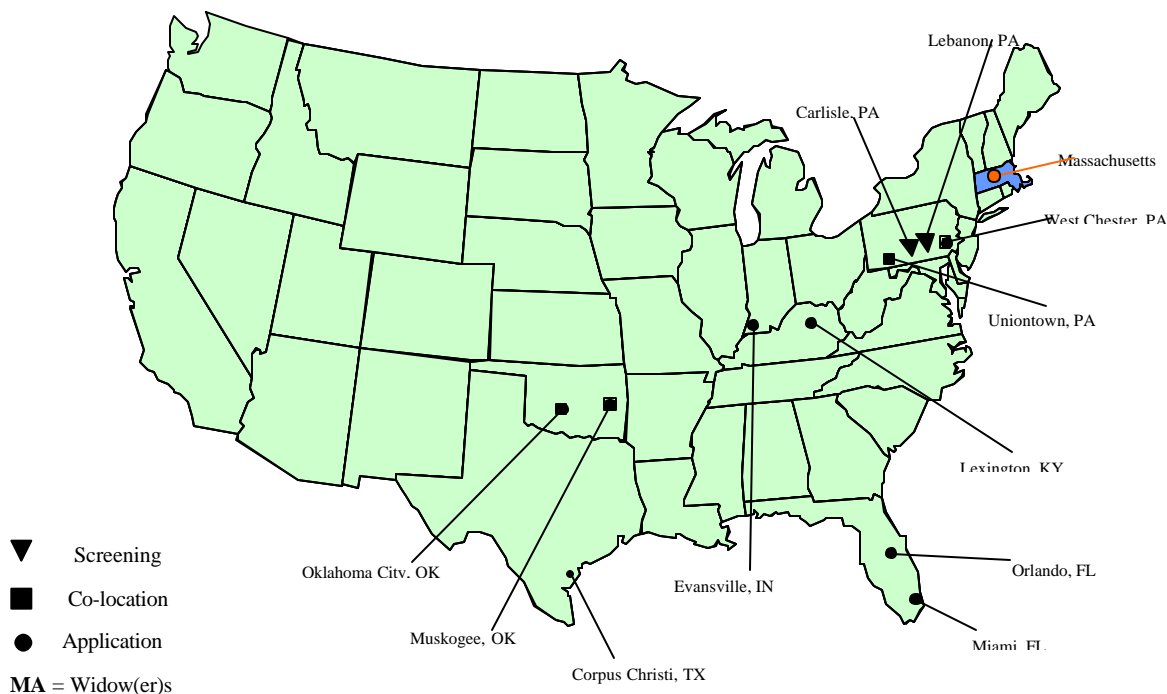
**Exhibit 1.3**  
**Buy-in Demonstration Sites**

Site	Main Demonstration Area	SSA Field Office
<b>Screening Model</b>		
Cumberland County, PA	Cumberland County	Carlisle
Perry County, PA	Perry County	Carlisle
Lebanon County, PA	Lebanon County	Lebanon
<b>Co-location Model</b>		
Chester County, PA	Chester County	West Chester
Fayette County, PA	Fayette County	Uniontown
Muskogee, OK	Adair, Cherokee, McIntosh, Muskogee, and Wagoner Counties	Muskogee
Oklahoma, OK	Oklahoma County	Oklahoma City
<b>Application Model</b>		
Fayette County, KY	Fayette County	Lexington
Miami, FL	Little Havana, Miami	Miami Central
Nueces County, TX	Nueces County	Corpus Christi
Orlando, FL	Osceola and Orange Counties	Orlando
Vanderburgh County, IN	Vanderburgh County	Evansville
<b>Widow(er)s Model</b>		
Massachusetts	State of Massachusetts	All field offices

The states were asked to submit a list of at least four low-income communities that would be good candidates for participation in the demonstration. Also, the states were asked to submit comparison sites, communities that would not participate in the demonstration but were similar enough to be used for the impact analysis. In addition, it was requested that the states assure that they would provide application data and, in the case of the co-location model, staff to be located at the SSA office. The demonstration did not provide funds to reimburse the states for expenses related to the demonstration.

After further discussions with the states, specific communities were selected for the demonstration. Some states chose cities, Metropolitan Statistical Areas (MSA), or counties although others chose the field office catchment areas as geographic boundaries. Originally, Massachusetts offered to operate all four demonstration models but ultimately decided to operate only the widow(er)s model. As a result, the widow(er)s model was expanded to include the entire State of Massachusetts, rather than one county. *Exhibit 1.3* lists the demonstration sites, the areas covered by the demonstration, and the corresponding SSA field offices selected for each model. (See *Exhibit 1.4* for a map showing all demonstration sites.)

**Exhibit 1.4**  
**SSA Offices (Demonstration Sites)**



## B. Participating Sites

Thirteen states expressed an interest in participating, although three states were not considered because they responded after the deadline. Seven states were ultimately selected for the demonstration: Florida, Indiana, Kentucky, Massachusetts, Oklahoma, Pennsylvania, and Texas.

The communities selected for the demonstration comprise a geographically diverse mix of urban and small metropolitan/rural sites. The sites vary in economic and demographic characteristics of their elderly populations. *Exhibit 1.5* summarizes the economic and demographic characteristics of the population age 65 or older living in each site. These data are drawn from the 1990 Census.

Miami is the most disadvantaged community among the demonstration sites: It has the highest percentage of elderly living in poverty, the lowest percent who own a home or a car, and the highest share of senior citizens with self-care limitations. Hispanics make up a sizable portion of

the senior citizens in Miami, Florida, and Nueces County, Texas. The Pennsylvania counties, with the exception of Fayette, have a relatively low share of seniors living in poverty, a higher percentage owning a home and a car, and a lower percentage with self-care limitations. About 33 percent of the senior citizens in the selected sites live alone, and about 60 percent are female.

**Exhibit 1.5**  
**Economic and Demographic Characteristics of**  
**1990 Population Age 65 or Older, by City or County**  
**(percentage with characteristic)**

Site	In Poverty	Black	Hispanic	Female	Live Alone	With Self-Care Limits	Own Home	Own Vehicle
<b>Screening Model</b>								
Cumberland County, PA	6.0	0.7	0.3	60.4	29.8	14.3	77.1	85.0
Perry County, PA	11.2	0.0	0.2	57.4	28.1	18.3	82.2	80.6
Lebanon County, PA	8.7	0.2	0.2	60.3	32.0	16.1	73.6	77.8
<b>Co-location Model</b>								
Chester County, PA	6.1	5.6	0.6	58.8	24.9	16.1	76.2	83.4
Fayette County, PA	14.5	3.6	0.2	60.1	32.4	24.5	79.9	73.7
Muskogee, OK	18.2	15.2	0.2	62.1	39.0	21.7	72.8	78.5
Oklahoma City, OK	13.1	10.8	1.1	61.7	35.0	20.7	78.2	83.0
<b>Application Model</b>								
Fayette County, KY	13.2	12.5	0.3	62.7	32.7	21.3	69.9	75.7
Miami, FL	32.2	11.9	73.1	60.9	27.3	27.4	40.5	54.3
Nueces County, TX	20.2	5.0	36.0	59.0	29.4	22.9	74.5	81.2
Orlando, FL	16.1	16.7	5.3	62.6	34.1	20.6	65.3	73.7
Vanderburgh County, IN	11.6	5.3	0.2	63.2	35.9	21.4	74.7	76.6
<b>U.S. Total</b>	<b>12.8</b>	<b>8.0</b>	<b>3.4</b>	<b>59.9</b>	<b>30.5</b>	<b>20.1</b>	<b>75.0</b>	<b>22.3</b>

Source: The Lewin Group tabulations of 1990 Decennial Census.

#### IV. ORGANIZATIONS INVOLVED

Getting the demonstration off the ground involved a collaborative effort among several offices within SSA, the Health Care Financing Agency (HCFA), state agencies, and SSA field offices. SSA led the effort, although it received assistance from HCFA and state agencies that advised SSA, supplied important data, trained SSA staff, and handled other responsibilities discussed below.

##### A. Social Security Administration Central Staff

SSA demonstration staff were assigned from the Office of Program Benefits, the Operations Office, the Systems Office, and the Office of Research, Evaluation, and Statistics. The Office of Program Benefits staff assumed overall responsibility for designing and implementing the demonstration, with input and review from Congress, DHHS, and other SSA offices. The Office of Program Benefits oversaw the implementation of the demonstration but was assisted by staff from other SSA offices.

During the planning phase, SSA proposed three of the demonstration models (screening, co-location, and application), solicited participation from the states, and, after discussions with the states, selected specific demonstration sites, with the Office of Program Benefits taking the lead. SSA Operations staff operated the DSU. Both offices were involved with drafting training materials, training staff, and acting as liaisons with the SSA field offices. Office of Program Benefits staff conducted site visits to all field offices and state agencies during the early phase of implementation to identify potential problems, often accompanied by staff from the Operations Office. The Systems Office developed the screening tool based on requirements from the Office of Program Benefits and continued to respond to systems questions from the field offices and the DSU throughout the demonstration. Finally, the Office of Research, Evaluation, and Statistics is overseeing the evaluation of the demonstration.

## **B. Direct Service Unit**

SSA created and staffed the DSU in Baltimore, Maryland, for the demonstration. The DSU was responsible for answering all calls to the special toll-free number established for the demonstration and for screening callers from 6:30 A.M. to 7:30 P.M. Monday through Friday. Given the expected volume of calls, the DSU had 41 staff, some of whom were service representatives (SR) and benefit authorization employees familiar with the Buy-in programs and others who were new to the program and required more training. There were five bilingual screenings.

## **C. Social Security Administration Field Offices**

SSA field offices were responsible for screening beneficiaries who decided to visit the local field office rather than call the DSU. Field office managers also were asked to conduct various outreach efforts to inform the public about the demonstration. This included displaying posters and brochures and informing the media. SSA staff who implemented the application model also met with staff from the state Medicaid agency to learn how to correctly complete the applications.

## **D. Health Care Financing Agency**

HCFA was involved during the planning phase of the demonstration and has reviewed and provided comments on much of the material produced for the demonstration, including the draft of the Federal Register notice.

## **E. State Medicaid Agencies**

Depending on the state, a number of state agencies were involved in the demonstration. Although the agencies use a variety of names (e.g., Department of Public Assistance, Children and Family Services, and Department of Human Services), in this report they are generically referred to as “state Medicaid agencies.”

Cooperation and assistance from state Medicaid agencies were vital to the operation of the demonstration in several ways: 1) Depending on the model, the states set aside appointment slots for taking applications, provided a state worker to take applications at the SSA office, or trained SSA staff to take applications; 2) states had to be prepared for an increase in the volume of

applications that would have to be processed, if the demonstration proved effective; and 3) states continue to supply SSA with individual-level enrollment data for Buy-in beneficiaries. These data provide The Lewin Group the key outcome measures needed to gauge the effectiveness of the demonstration.

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## CHAPTER 2: METHODS AND DATA SOURCES

The cooperation among the Social Security Administration (SSA) and other agencies facilitated not only the demonstration implementation but also the collection of process-related information and data for the outcome analysis outlined throughout the report. Primary data sources for this report include interviews, screening data, Master Beneficiary Record (MBR) data, and a matched screening–MBR data set.

This chapter is divided into two sections. The first describes the interviews which provide the bulk of the qualitative information discussed throughout the report. The second section addresses the data sets used for the analyses in chapters 3, 4, and 5.

### I. INTERVIEWS

The Lewin Group staff conducted interviews with SSA central office staff, SSA staff at the Direct Service Unit, SSA field office staff, and state Medicaid agency staff from March 1999 through January 2000. *Exhibits 2.1* and *2.2* list the method and date of contact with SSA staff, while *Exhibit 2.3* lists the method and date of contact with state Medicaid agency staff.

#### A. Initial Telephone Contact

Telephone interviews were conducted with all SSA field office and state liaisons early in the implementation phase. The Lewin Group staff interviewed SSA liaisons at the SSA field office to learn about start-up activities at the field office level. The discussion centered on outreach efforts, the screening tool, staffing, training, and data transmission. Where applicable, model-specific questions were asked. Co-location model staff were asked about the co-located worker, application model staff were asked to discuss the application process, while widow(er)s model staff were asked about the identification of clients to screen.

The Lewin Group staff also interviewed state Medicaid agency liaisons. Discussion centered on the application process for Buy-in benefits and data availability on applications and enrollment for Buy-in benefits. Specific outreach efforts used by states to increase participation in Buy-in benefits were also discussed.

#### B. Site Visits

The Lewin Group staff visited two communities in each model to interview line staff and managers and learn firsthand about their experiences with the demonstration. The site visits were done in conjunction with SSA operation staff, in an effort not to overburden the SSA field offices. At each field office, interviews were conducted with the field office manager, screening staff, and county Medicaid agency staff, who were invited to the SSA field office for the site visit. In application model sites, Lewin also met with (SSA) application staff. In addition, The Lewin Group staff visited the DSU in Baltimore, Maryland, and met with SSA project staff involved in the development and implementation phase of the demonstration.

**Exhibit 2.1**  
**Schedule of Interviews with SSA Staff**

Sites by Model	Initial Call	Site Visit	Follow-Up Call
<b>Screening Model</b>			
Carlisle, PA (Perry and Cumberland County)	March 17, 1999 Field office manager	May 13, 1999 Field office manager 2 screening staff 5 County Medicaid agency staff 1 state Medicaid agency staff	January 10, 2000 Field office manager
Lebanon, PA (Lebanon County)	March 17, 1999 Field office manager	May 14, 1999 Field office manager 2 screening staff 2 County Medicaid agency staff 1 state Medicaid agency staff	January 18, 2000 Field office manager
<b>Co-location Model</b>			
Muskogee, OK (Muskogee, Cherokee, Adair, Wagoner and McIntosh County)	April 8, 1999 Field office manager Co-located worker	June 16, 1999 Field office manager Co-located worker Area Medicaid agency director	January 12, 2000
Oklahoma City, OK (Oklahoma County)	April 13, 1999 Field office general coordinator	Did not visit	January 10, 2000 Field office general coordinator
Uniontown, PA (Fayette County)	April 12 Field office manager	Did not visit	January 10, 2000 Field office manager
West Chester, PA (Chester County)	April 8, 1999 Field office manager Field office assistant manager	June 25, 1999 Field office manager Field office assistant manager County Medicaid agency manager First co-located worker Second co-located worker	January 10, 2000 Field office manager

Exhibit 2.1—Continued

Sites by Model	Initial Call	Site Visit	Follow-Up Call
<b>Application Model</b>			
Miami, FL ( <i>Dade County</i> )	May 6, 1999 Systems	Did not visit	January 14, 2000 Field office systems staff
Orlando, FL ( <i>Orange and Osceola County</i> )	May 4, 1999 Field office assistant manager Field office systems staff	July 21, 1999 Field office manager Field office assistant manager Field office union representative <i>2 County Medicaid agency staff</i>	January 20 2000 Field office systems staff
Evansville, IN ( <i>Vanderburgh County</i> )	April 30, 1999 Field office management support specialist	Did not visit	January 11, 2000 Field Office management support specialist
Lexington, KY ( <i>Fayette County</i> )	May 3, 1999 Assistant district manager	Did not visit	January 12, 2000 Assistant district manager
Corpus Christi, TX ( <i>Nueces County</i> )	May 17, 1999 Field office manager	June 23, 1999 Field office manager 1 Screening staff 1 Application staff <i>4 County Medicaid agency staff</i> <i>1 State Medicaid agency staff</i>	January 12 2000 Field office manager
<b>Direct Service Unit</b>	March 19, 1999 Direct Service Unit Director	May 28, 1999 Direct Service Unit manager 7 Screening staff	January 10, 2000 Field office manager
<b>Central Office</b>		Sept 27 and 29, 1999 2 Program Benefits staff 3 Operations staff	

Note: DSU = Direct Service Unit

**Exhibit 2.2**  
**Schedule of Interviews with Massachusetts SSA Staff**

Sites by Model	Initial Call	Site Visit
<b>Widow(er)s Model</b>		
Attleboro	April 29, 1999	Did not visit
Boston	May 4, 1999	Did not visit
Brockton	April 29, 1999	Did not visit
Brookline	May 17, 1999	June 14, 1999
Chelsea	May 27, 1999	Did not visit
Dorchester	May 12, 1999	Did not visit
Fall River	May 4, 1999	Did not visit
Falmouth	April 29, 1999	Did not visit
Fitchburg	May 20, 1999	Did not visit
Framingham	June 4, 1999	Did not visit
Gardner	May 14, 1999	Did not visit
Greenfield	May 27, 1999	Did not visit
Hanover	May 11, 1999	Did not visit
Haverhill	May 4, 1999	September 13, 1999
Holyoke	June 15, 1999	Did not visit
Hyannis	May 6, 1999	Did not visit
Lawrence	May 12, 1999	Did not visit
Lowell	May 17, 1999	Did not visit
Lynn	May 4, 1999	Did not visit
Malden	May 12, 1999	Did not visit
New Bedford	May 4, 1999	Did not visit
North Adams	May 7, 1999	Did not visit
Norwood	May 10, 1999	Did not visit
Pittsfield	May 5, 1999	Did not visit
Quincy	May 21, 1999	Did not visit
Roslindale	May 6, 1999	Did not visit
Roxbury	April 30, 1999	Did not visit
Salem	May 10, 1999	Did not visit
Somerville	May 17, 1999	Did not visit
Springfield	May 4, 1999	Did not visit
Taunton	April 30, 1999	Did not visit
Waltham	May 3, 1999	Did not visit
Worcester	June 4, 1999	Did not visit

**Exhibit 2.3****Schedule of Interviews with State Medicaid Agency Staff**

<b>State, County, City (Field Office)</b>	<b>Initial Call</b>	<b>Site Visit</b>	<b>Follow-Up Call</b>
<b>Florida</b>	April 1, 1999		
Dade County ( <i>Miami</i> )			January 18, 2000
Orange County Region ( <i>Orlando</i> )		July 23, 1999	January 7 and 13, 2000
<b>Indiana</b>	March 31, 1999		
Vanderburgh County ( <i>Evansville</i> )			January 13, 2000
<b>Kentucky</b>	April 1, 1999		
Fayette County ( <i>Lexington</i> )			January 13, 2000
<b>Massachusetts</b>	May 27, 1999		
Revere County		June 14, 1999	
Tewksbury County		September 13, 1999	
<b>Oklahoma</b>	June 8, 1999		
Muskogee County ( <i>Muskogee</i> )		June 16, 1999	January 12, 2000
Oklahoma County ( <i>Oklahoma City</i> )			January 12, 2000
<b>Pennsylvania</b>	April 1, 1999		
Chester County ( <i>West Chester</i> )		June 25, 1999	January 14, 2000
Cumberland County ( <i>Carlisle</i> )		May 13, 1999	January 7, 2000
Fayette County ( <i>Uniontown</i> )			January 13, 2000
Lebanon County ( <i>Lebanon</i> )		May 14, 1999	January 7, 2000
Perry County ( <i>Carlisle</i> )		May 13, 1999	January 13, 2000
<b>Texas</b>	April 1, 1999		
Nueces County ( <i>Corpus Christi</i> )		June 23, 1999	January 12 and 13, 2000

The discussion with SSA field office staff focused on the volume of calls and walk-ins as a result of the Buy-in program, training, screening process, scheduling of applications, effectiveness of outreach efforts, general staff impressions, and model specific issues. The discussion with county Medicaid agency staff centered on application process, screening process, relationship with SSA, staffing, and outcomes.

**C. Follow-up Telephone Contact**

The Lewin Group staff conducted follow-up telephone calls with all SSA field office and state Medicaid agency staff after the demonstration was completed to learn about changes that had occurred after the initial telephone contact or site visit and to fill gaps in knowledge about implementation of the demonstration. The follow-up telephone calls were particularly informative for sites The Lewin Group staff did not visit.

## **II. DATA SOURCES**

The Lewin Group staff obtained data from a variety of sources to describe and document the outreach efforts and screening process discussed in Chapters 4 and 5.

### **A. Screener Data**

As Chapter 4 discusses at greater length, the outreach efforts directed potential Buy-in participants to call the toll-free number at the DSU or visit their local welfare, medical assistance, or Social Security office. If a potential participant called the DSU or visited the local Social Security office, the individual was screened using a PC program.<sup>18</sup> The screening process is discussed briefly here and more thoroughly in Chapter 5.

#### **1. Overview of the Screening Tool**

The screening program began with basic questions about the individual's Social Security number (SSN), first and last names, address, spouse's name and SSN, zip code, gender, and Spanish language preference (yes/no). If the individual's zip code were outside a demonstration area, the screening was terminated. The interviewer explained to the individual that his or her area of residence was outside the scope of the demonstration and that the screening would not continue. The individual might have been encouraged to contact his or her local Medicaid office.

If the individual's zip code was valid, the screening continued with questions concerning how the individual learned about the Buy-in program, resources, and income. If the individual was deemed potentially eligible (i.e., his or her Title II benefit, resources, and income fell below the required amount and he or she met the other necessary criteria), the interviewer was prompted to make an application appointment, and the individual was sent an appointment letter. The PC program saved the information and created a record for each individual.

The screening automatically terminated and the individual was deemed potentially ineligible if he or she: 1) lived outside the demonstration area; 2) was not entitled to Medicare Part A; or 3) was receiving the Medicare Part A premium for working individuals. Automatic termination and potential ineligibility also occurred if the individual or couple's 1) monthly Title II income was too high; 2) resources exceeded the financial resources; or 3) income exceeded the limits.

Every two weeks, the DSU and SSA field offices downloaded the screening records and sent a file with data from the previous two weeks to a central location, where the files were merged. Files were sent to The Lewin Group for analysis.

The screening data used for this report cover the period from March 16, 1999 through December 31, 1999 and include a total of 16,028 individual records (following the deletion of duplicates).

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<sup>18</sup> Appendix C includes the screening program.

## **2. Data Cleaning**

Review of the first set of screening data made apparent that many individuals had multiple records. Of the first 717 records analyzed in this four-week data set, only 421 individuals were included after removing duplicates; analysis of the 717 records revealed that some individuals had as many as 14 records. These duplicates had the same SSN, but different entry dates or times. SSA systems staff deleted exact duplicates from the data before sending the data to The Lewin Group.

Not all of the intricacies in the duplicated records could be explained; however, it was realized that multiple records continued to occur for a variety of reasons, including the following:

- When, during the course of an interview, information was learned that applied to an earlier screen, the interviewer had to start a new screening because the software did not allow a return to the previous screen.
- Some duplicate records had time stamps several hours or days apart, indicating that perhaps the individual was unsure about a certain data point (e.g., the value of real estate property) and had to collect the information to update the interviewer at a later time; thus, a second record was generated to reflect the newer, more accurate information.
- Some individuals were inadvertently screened twice by one or more offices (including the DSU).
- Some field offices intentionally re-screened individuals.

As a result, it was assumed that the most recent screening record would likely be the most accurate, although it was recognized that this was not always the case.

Other data cleaning procedures were performed on the data set, as described below:

- Preliminary analyses were conducted to identify invalid codes, illogical and inconsistent responses, and missing data. Records with zip codes outside the demonstration area were disregarded (372 records). Inconsistencies with the invalid zip code, appointment letter, and denial letter variables were discovered with the early screening records (these were rare and occurred in initial data downloads). Although these variables should have been mutually exclusive, some records indicated that they were not. SSA Systems staff developed a hierarchy for categorizing these records. Invalid zip codes took precedence over denial and appointment letters, and denial letters took precedence over appointment letters. Thus, a record that had both a denial and an appointment letter was classified as having been denied. And subsequent fields for resource and income values were reviewed and confirmed to be zero for those whose screenings were terminated at an earlier point during the interview.
- The screening data might have included test cases used for training purposes. The Lewin Group staff attempted to identify test cases using criteria regarding valid SSNs provided by SSA. Two of the criteria were date sensitive and depended on the individual's date of birth. However, this variable was not on the screening data. Therefore, using all the possible

criteria, The Lewin Group staff determined that only two records were “impossible.” Upon closer analysis of these records, it was not clear whether or not they were actual test cases as they contained other input information (such as monthly Title II income amount) and uncommon names. As a result, for purposes of the preliminary report, no records were omitted.

- Simple descriptive statistics were produced to identify suspicious or large changes in client characteristics or outcomes that might indicate problems with the data submission. For example, screenings were grouped by office on a bi-monthly basis to ensure that each office was downloading and submitting its data to SSA.

## **B. Mailing of Extract Master Beneficiary Record Data**

MBR data, kept by SSA, were used to determine those individuals and couples who might be eligible for the Medicare Buy-in program. An extract of the data set provided a list of 239,110 individuals and couples who were sent an outreach letter. Each MBR record contained several demographic variables as well as variables concerning the individual and the spouse’s (where applicable) beneficiary status. For purposes of this report, married couples, both partners receiving benefits based on the primary claimant, were treated as one unit and all characteristics analyzed drew on the primary beneficiary’s information. For example, when age was reviewed, the primary beneficiary’s date of birth was used and the spouse’s was disregarded. The name fields were formatted for mailing purposes and, therefore, complicated some of the matching efforts.

## **C. Undelivered Letter Data**

SSA kept a record of undelivered letters; the count indicates that slightly more than one percent of the letters mailed were returned. The undelivered letter data set contained limited information concerning the reason why the letter was returned (including “undeliverable,” “moved,” “death,” “ineligible,” and “unread”) along with the name of the intended recipient(s) and the mailing date. Part of the reason for returned letters may be the prevalent use of direct deposit, which reduces the need for an accurate mailing address for beneficiaries. This information does not fully capture whether a letter was not received, only if it was returned.

## **D. Matched Screener–Master Beneficiary Record Data**

MBR data were matched to the screening data set for two reasons: to enable the analysis of several variables not included in the screening tool (e.g., date of birth); and to analyze the number screened and calculate potential eligibility as a function of the number of people sent letters.

After the duplicates on the screening data were removed, the set was matched to the MBR using the primary beneficiary’s SSN. Only those who were sent letters could potentially be matched to the MBR data set. Thus, individuals who heard about the demonstration through other outreach efforts were not included in the MBR letter file. According to the screening data, approximately 86 percent (13,500 individuals) of those screened *reported* that they received a letter. However, the number of records that matched total 14,330, a match rate of around 91 percent. While it is



possible that some of the latter group did not receive a letter, it is assumed that many did not report that they had heard of the program through an outreach letter.

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## **CHAPTER 3: START-UP OF THE DEMONSTRATION**

The Social Security Administration (SSA) set the broad parameters for how the models would be implemented, but within this framework, the SSA field offices and state Medicaid agencies made local decisions regarding staffing, training, outreach, and the application requirements. The purpose of this chapter is to describe the start-up phase of the demonstration. The first section focuses on the field office and state Medicaid agency practices in place at the beginning of the demonstration. The second section discusses the models that SSA intended to test. The third and fourth sections describe the decisions made by the regional SSA offices and state Medicaid agencies to staff the demonstration and train employees, respectively. The experiences of the sites in implementing the models are discussed in Chapters 4, 5, and 6.

### **I. BUY-IN PRACTICES BEFORE THE DEMONSTRATION**

A number of reports have highlighted the lack of participation in Buy-in programs in recent years, focusing attention on this issue and spurring federal agency, state government, and advocacy group efforts to increase enrollment of eligible individuals. This is important for interpreting the enrollment impacts that will be presented in a future report. Specific efforts in some communities might already have reached a large portion of the group targeted by the demonstration. A number of variables that might have been associated with Buy-in enrollment include SSA field office practices, outreach activities, and state application practices in place before the demonstration.

#### **A. Field Office Practices**

In 32 states, SSA determines categorical eligibility for Medicaid among Supplemental Security Income (SSI) applicants; in these states, Buy-in is determined as part of the SSI/Medicaid decision. Neither Oklahoma nor Indiana is among the states that determine eligibility in this manner.

Staff at all SSA field offices reported that they referred clients to the state for Buy-in when appropriate before the demonstration. However, screening personnel from different field offices appeared to have varying opinions about what constituted an appropriate client. One screening indicated that she would refer a client to the state for Buy-in benefits if the client appeared to be in dire need although in other offices staff might refer clients who were applying for SSI and appeared to be eligible. In addition, most field offices expressed doubt that the majority of clients referred ever actually contacted the state to apply for Buy-in benefits.

#### **B. Outreach in Demonstration Communities**

It is important to note the extensive Buy-in outreach efforts in the demonstration sites before the demonstration period. The evaluation will consider these activities when interpreting the results of the impact analysis. Outreach included major efforts as described below:

- Co-located state workers had been working in both Oklahoma demonstration field offices and in the Tulsa, Oklahoma field office starting in October 1998. Initially, the co-located worker focused on increasing participation in the Children's Health Insurance Program

(CHIP); the worker's responsibilities were later expanded to include taking Medicaid applications on-site.

- Just before the demonstration, the Health Care Financing Administration (HCFA) conducted a targeted letter campaign in Texas, Michigan, and New York, attempting to increase enrollment in the Buy-in program. Letters were sent to individuals entering the Medicare program who had Social Security income below 100% of the federal poverty guideline. State and SSA field staff agreed that the letter campaign appeared to have little impact on Buy-in enrollment.<sup>19</sup>
- In Massachusetts, the aging community has been extremely well organized in educating low-income seniors about their insurance options and enrolling them into a range of programs, including the Buy-in program. One extensive outreach effort organized by SHINE, Serving Health Information Needs of Elders, involves including information on Buy-in programs in all materials, training, and counseling efforts and assisting the low-income population with the enrollment process. ElderCare, an advocacy group for the elderly, has also been actively conducting outreach in the state. Many of the SSA field and state staff interviewed for this evaluation suggested Massachusetts' already high enrollment rate as one reason for the low client volume under the demonstration.

### C. States' Application Processes

*Exhibit 3.1* presents information on the application process in each state before the demonstration.

#### 1. Forms Used and Evidence and Verification Requirements

Some states have modified the length of the application and the evidence and verification requirements to make it easier to apply for Buy-in benefits (see discussion in Chapter 6). The shorter Buy-in applications tend to be one or two pages in length. As *Exhibit 3.1* shows, before the start of the demonstration, only Kentucky and Texas were using a short application. In the other states, individuals wishing to apply for Buy-in benefits were required to fill out the application used for full Medicaid and other benefits, such as Temporary Assistance to Needy Families (TANF) and food stamps.

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<sup>19</sup> Booz, Allen and Hamilton, Inc. (1999). Evaluation of 1998 Benefits Letter Campaign "Medicare Savings for Qualified Beneficiaries." Report to Health Care Financing Administration (Baltimore, MD). According to this report, Texas Department of Human Services (DHS) mailed 60,487 benefits letters to individuals living in 11 regions in the state. From this mailing, 5,206 individuals requested additional information and 286 were subsequently approved for assistance. Most of those who initially requested information did not return their application (4,328 of the 5,206).

**Exhibit 3.1****State Application Process Characteristics before the Demonstration**

	<b>FL</b>	<b>IN</b>	<b>KY</b>	<b>MA</b>	<b>OK</b>	<b>PA</b>	<b>TX</b>
<b>Application Form</b>							
Shorter Buy-in application			X				X
Application includes benefits other than Buy-in	X	X	No, but worker inquires if clients are eligible	Full Medicaid only	X	X	
<b>Evidence/Verification Requirements</b>							
Self-declaration accepted							X Conduct QC and match to SS information
<b>Application Submission</b>							
Method of intake	Generally in person; phone if nursing home or out-of-state relative	In person or phone; by mail if disabled	Generally in person; unless physical reason to do phone; proxy can apply	Primarily phone or mail; four centralized processing centers not conducive to in-person	In person, phone, or mail	In person or phone; some exceptions by mail	In person or phone; can mail application, but require interview
Home visits scheduled	For health reasons	Not normally	For health reasons	No	For health reasons	For health reasons	For health reasons
Effective date for benefits	Date of request for assistance form	1 <sup>st</sup> of month following approved application	<ul style="list-style-type: none"> <li>• QMB – 1<sup>st</sup> of month following approved application</li> <li>• SLMB and QI – 3 months before date of application</li> </ul>	1 <sup>st</sup> of month following approved application	<ul style="list-style-type: none"> <li>• QMB – 1<sup>st</sup> of month following approved application</li> <li>• SLMB and QI – 3 months before date of application</li> </ul>	<ul style="list-style-type: none"> <li>• Buy-in – 1<sup>st</sup> of month following approved application</li> <li>• Medical – date of application</li> </ul>	<ul style="list-style-type: none"> <li>• QMB – 1<sup>st</sup> of month following approved application</li> <li>• SLMB and QI – 3 months before date of application</li> </ul>

**Exhibit 3.1—Continued**

	FL	IN	KY	MA	OK	PA	TX
<b>Processing Time Requirements</b>							
Number of days	45 days	45 days	30 days	45 days	30 days	30 days	45 days
From (initial contact, appointment, completed application)	Initial application date	Initial application date	Date of filed application or mailing of application	Completed application	Completed application	Completed application; which could be prior to appointment, but usually was not	Completed application
<b>Recertification Requirements</b>							
Time period	Annual	Annual	Annual	Annual	Annual	Annual	Annual
In-person required	Generally in person; phone if nursing home or out-of-state relative	By mail or phone; send out same releases	Generally in-person also	Primarily phone or mail	In person, phone, or mail	In-person, although some exceptions by county and case	In person, phone, mail; send out form; will go retrieve if not returned
Evidence/verification	Income and assets	Income and assets	Income and assets	Income and assets	Income and assets	Income and assets	Not required
<b>Resource Limits for QMB/SLMB</b>							
Individuals	\$5,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000
Couples	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000	\$6,000
<b>Income limit for elderly/disabled full Medicaid benefits</b>							
As a % of federal poverty level	90%	74% Federal SSI	74% Federal SSI	82% State SSI Support	100%	100%	74% Federal SSI

Source: The Lewin Group interviews with state Medicaid liaisons.

Before the demonstration, all participating states except Texas required some evidence to support the income and resources listed on the application. These included proof of Medicare Part A receipt, recent bank statements, property deeds, life insurance policies, financial statements, and funeral or burial policies. Some states pursue verification through third parties although others require the applicant to submit all verification.

Texas relies on client declaration for Buy-in benefits. The rationale for reduced verification is that the expected Buy-in benefits are less than full Medicaid benefits and the paperwork burden of providing evidence in support of stated income and resources might discourage some potentially eligible individuals from applying. In addition, it reduces the financial burden of staff time for the state. Since October 1998, the state has been conducting a quality control pilot, verifying the income and resource information listed on a sample of applications. If the state determines that there is more fraud associated with client declaration, they will change their policy and require more verification.

## **2. Application Submission**

To encourage participation, many states did not require face-to-face interviews before the demonstration but required at least telephone contact. Based on conversations with state Medicaid agency staff, under certain circumstances (e.g., an applicant's having severe disabilities) Indiana allowed applicants to submit their entire application by mail, Oklahoma routinely permitted application completely by mail, and Massachusetts had a preference for doing the entire process by mail. Florida and Kentucky had a strong preference for in-person interviews but permitted telephone interviews in certain circumstances. Five states (Florida, Kentucky, Oklahoma, Pennsylvania, and Texas) scheduled home visits for those in poor health to help with the application process.

## **3. Effective Date of Benefits**

The participating states vary in their effective date for benefits. Six states use the first of the month following approval of the application. Kentucky, Oklahoma, and Pennsylvania permit three months' retroactive eligibility for SLMB and QI-1 recipients. Florida provides benefits based on the date of application. The Medicaid agency has 45 days to process the application. Of the states in this demonstration, three (Kentucky, Oklahoma, and Pennsylvania) used the shorter standard of 30 days.

The policies that states use to determine the effective date of benefits for state programs differ from that used by SSA for SSA entitlements. SSA's philosophy is to "protect" the beneficiary from the date of first contact regarding an inquiry about benefits. This means that as soon as a client is approved for benefits, those benefits are retroactive to that date of first contact, regardless of the amount of time required for adjudication.

## **4. Recertification**

All states conduct recertification of eligibility annually, and most use intake and verification processes similar to that of the initial application. Pennsylvania was an

exception, in that the state allowed phone interviews for initial intake but required in-person interviews for recertification.

## **5. Financial Criteria for Eligibility**

Income limits for the Buy-In programs are established by statute. States can vary financial resource requirements. Among the participating states, Florida uses a higher resource limit for individuals—\$5,000 rather than \$4,000. Overlap between the income criteria for Buy-in and full Medicaid benefits (which states have greater latitude in establishing financial criteria for eligibility) might influence Buy-in participation and state processes. Three of the seven participating states used federal SSI as the income cutoff (74 percent of the poverty guideline), two used 100 percent of the poverty guideline, and the remaining two used points in between.

## **II. INTENDED SEQUENCE OF EACH DEMONSTRATION MODEL**

*Exhibit 3.2* illustrates the planned sequence of events under the demonstration after beneficiaries in the screening, co-location, and application models learned of the program. (The widow[er]s model is not included in the diagram.) These models begin with outreach efforts made by SSA staff. After learning about the program, it was the responsibility of the Medicare beneficiary to contact either the Direct Service Unit (DSU) or the local SSA field office. The descriptions below are based on the original design of the demonstration.

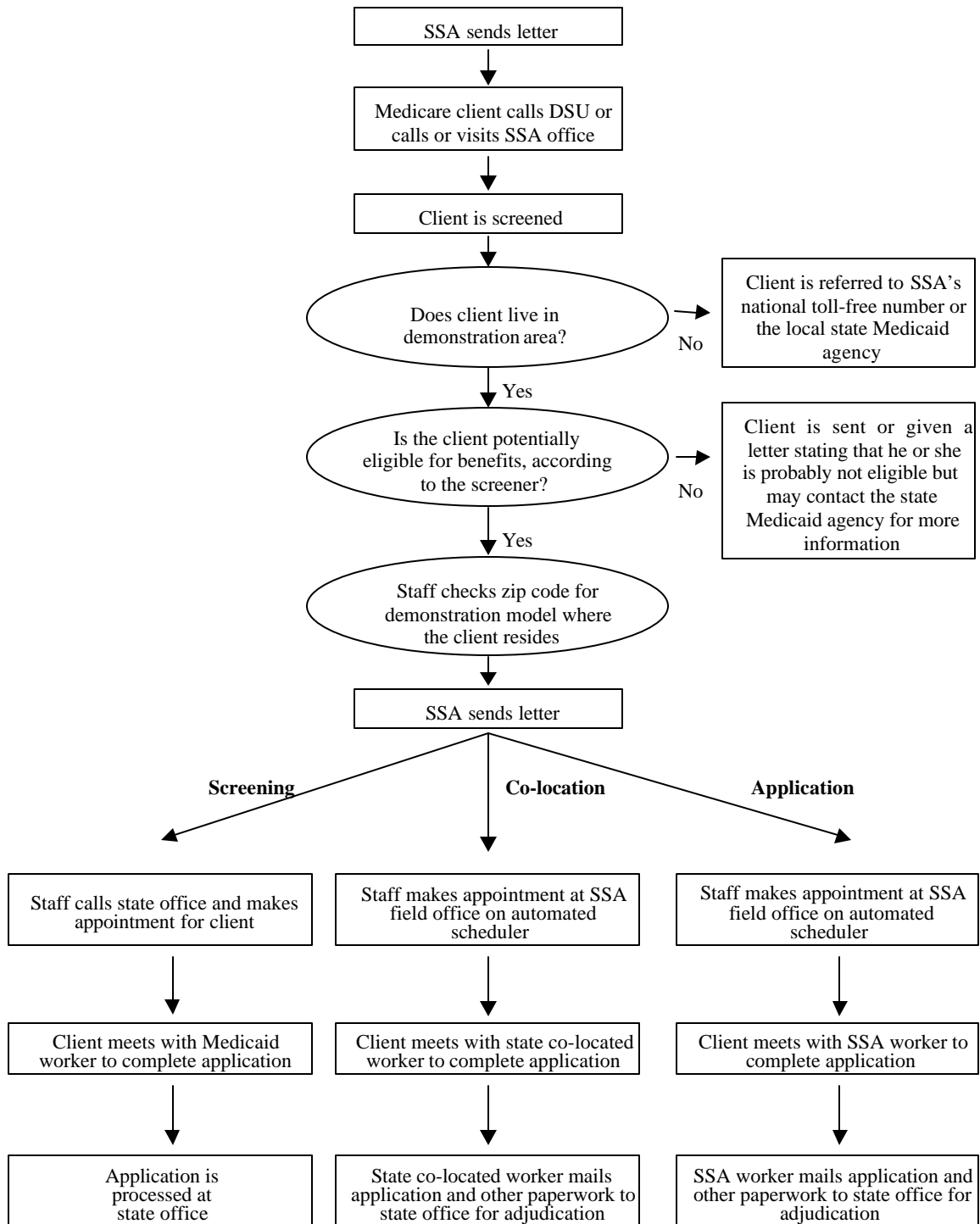
### **A. Screening Model**

The screening model aimed to make low-income Medicare beneficiaries aware of the Buy-in program's existence and eligibility requirements. With eligibility screening, the cost to the beneficiary of applying, in time and effort, stayed the same, but the benefit from applying increased because the uncertainty of the outcome was much lower. The assumption was that beneficiaries might be more willing to make a separate trip to the state welfare agency and apply for the Buy-in program if they are told they might be eligible.

In the screening model, SSA staff at the DSU and the SSA field offices performed Medicare Part B eligibility screening. The staff determined that the beneficiary was living in the screening catchment area (i.e., Carlisle and Lebanon, Pennsylvania) and potential eligibles were then directed to the state Medicaid agency to file an application.



**Exhibit 3.2**  
**Intended Sequence of Events by Model**  
**for Screening, Co-location, and Application Models**



When possible, SSA staff made an appointment for potential beneficiaries with the Medicaid agency at the time they were screened. SSA then sent the beneficiary a follow-up letter, reminding him or her of the appointment time and office location. In addition, the letter listed the information the individual needed to complete the application, i.e., proof of Medicare Part A receipt, recent bank statements, property deeds, life insurance policies, financial statements, funeral or burial policies, and proof of income. If an appointment could not be made, a letter was generated directing the client to call the Medicaid agency and make an appointment. These letters were also mailed or faxed to the Medicaid agency along with the beneficiaries' resource and income information from the screening.

Denial letters were sent to individuals whose income and resources exceeded the limits to inform them, in writing, of why they were deemed ineligible. In addition, the letter advised them that they could contact the state Medicaid agency to apply for other benefits or to receive a formal decision about their eligibility in the Buy-in program.<sup>20</sup> These denial letters were also sent to the state Medicaid agency.

## **B. Co-location Model**

Like the screening model, the co-location model included publicity about the Buy-in program and eligibility screening. The model differed in that potential eligibles could file an application form with a state welfare worker out-stationed at the local SSA field office. This model obviated the need for beneficiaries to travel to the state Medicaid agency by allowing them to go to the more familiar local SSA office. The model also assumed that beneficiaries might be more likely to apply for benefits at the local SSA office than at the state welfare agency because of the stigma associated with welfare.

For individuals screened to be potentially eligible, the SSA staff made an appointment directly with the state Medicaid agency on the SSA calendar system at the time of the call, thus eliminating the need to call to make an appointment. SSA sent the potential beneficiary an appointment letter with the time and date of the appointment. Walk-ins to the SSA office who were screened to be potentially eligible were seen immediately by the co-located state worker if he or she were available.

## **C. Application Model**

In addition to the outreach and screening efforts cited in the first two models, the application model enabled potential eligibles to file a Buy-in application at the local SSA office. Unlike the co-location model, an SSA employee took the application. The application model aimed to remove most obstacles from the initial application process. The beneficiary only needed to provide documentation of his or her income and assets.

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<sup>20</sup> See *Appendix E* for examples of the three letters and the income and resource form.

#### **D. Widow(er)s Model**

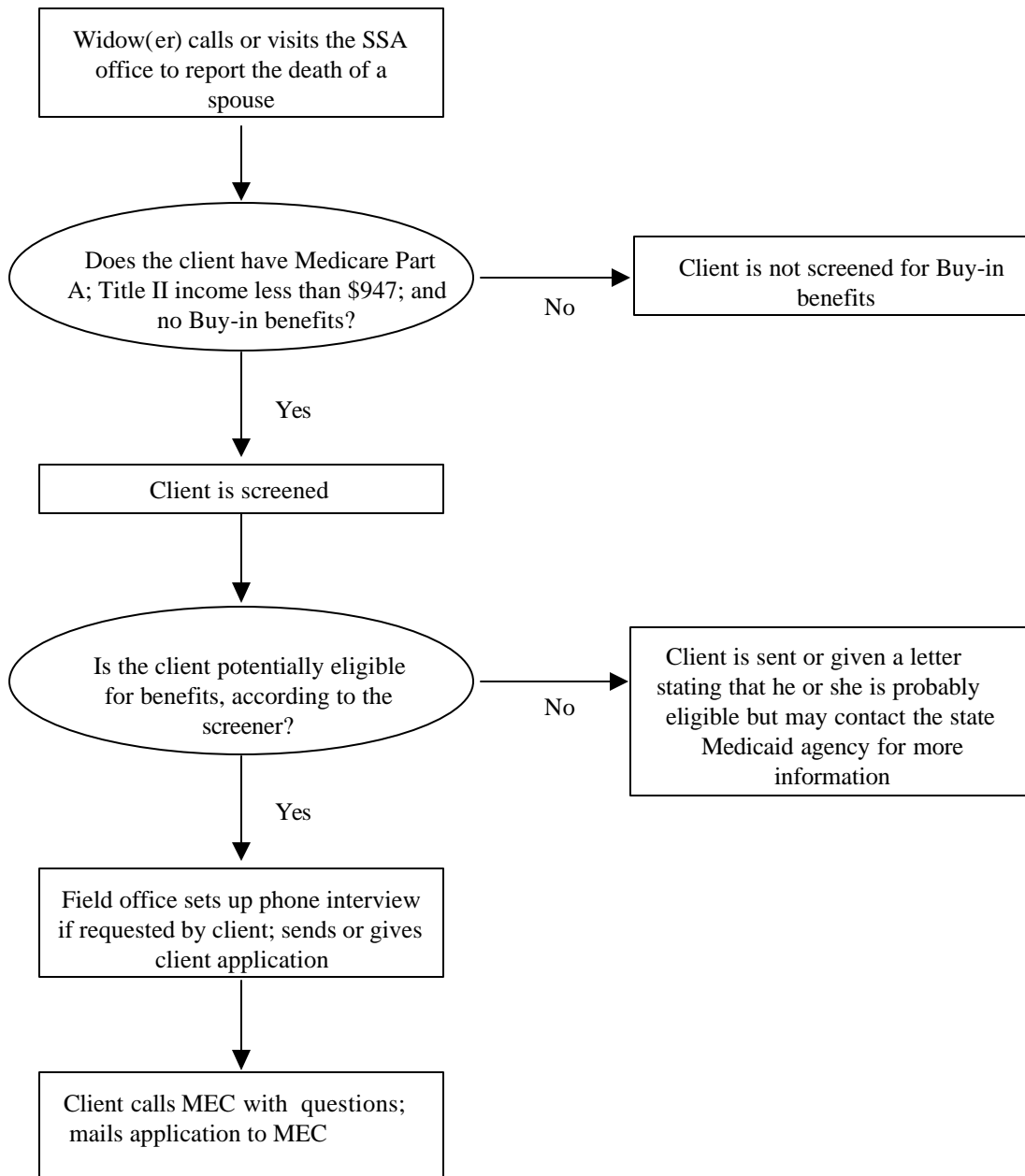
The widow(er)s model attempted to increase awareness among widowed low-income beneficiaries of the Buy-in program's existence and eligibility requirements immediately following the death of a spouse. The process was similar to the screening model discussed previously but without the extensive outreach.

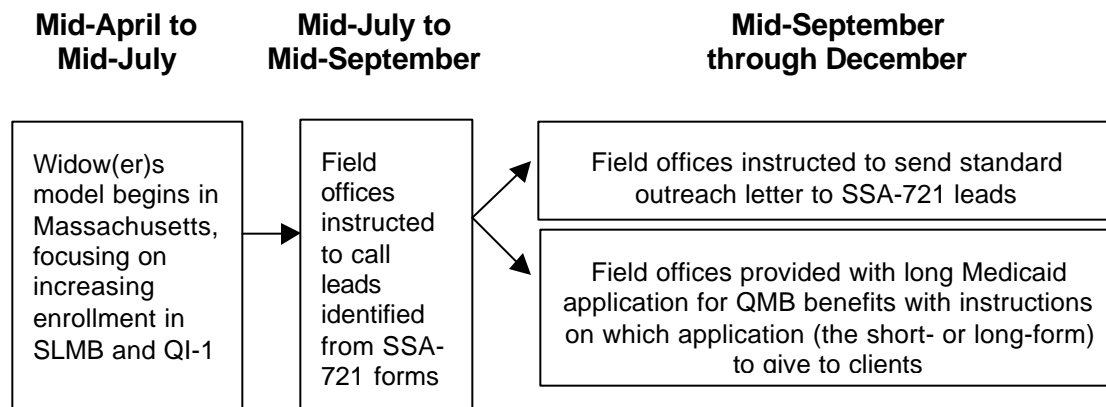
*Exhibit 3.3* presents the original intended sequence of events for the widow(er)s model. In this model, the SSA field office staff conducted an eligibility screening of a Medicare beneficiary who called or visited the field office to report the death of a spouse. Potential eligibles were directed to complete an application. Under the intended sequence of events, the SSA office then called the state Medicaid agency and scheduled an appointment for a phone interview, rather than scheduling an in-person appointment. The phone interview was offered because there are only four MassHealth Enrollment Centers (MEC) in the state, making travel to an office difficult for many beneficiaries. The client mailed an application to the MEC.

The widow(er)s model used in Massachusetts underwent several modifications over the course of the demonstration. (*Exhibit 3.4* displays the chronology of these changes.) The evaluation will take these changes into account.

Early in the demonstration, in response to the low volume of screenings and applications, at least one field office began using SSA-721 forms (i.e., funeral directors' death report forms) as leads and contacting appropriate clients for screening. This practice diverged from the original concept of identifying prospective Buy-in candidates from among widowed clients who contacted the field office for other reasons (most likely to change benefit status following death of a spouse). Calling beneficiaries based on SSA-721 leads became standard policy under the demonstration by mid-July. In mid-September, the process was further formalized when field offices were instructed to provide outreach letters to the leads identified through the SSA-721s, rather than to call them.

**Exhibit 3.3**  
**Intended Sequence of Events for Widow(er)s Model**



**Exhibit 3.4****Midcourse Changes to Widow(er)s Model**

At the demonstration's outset, the Massachusetts Medicaid agency distributed to the SSA field offices a relatively new shortened form to use specifically for SLMB and QI-1 benefits (thus, the form covers premiums but not co-payments or deductibles). To access Qualified Medicare Beneficiary (QMB) benefits, the state requires that the standard long Medicaid application be used. However, the state did not provide the standard long form to the field offices. After discussions between SSA and the state, it was agreed that these long forms would be distributed to all field offices, and procedures for QMB application would become a standard part of the widow(er)s model. The section describing the application process in Chapter 6 discusses the implications of the previous practice and this change.

**E. States' Role in the Demonstration**

In all four models, the states retained responsibility for adjudication of the application for Buy-in benefits. Although this would not be expected to have an impact on the success of the outreach functions of the alternative models in terms of the number of applications, it might have an impact on follow-through or ultimate benefit receipt. Under all four models, state agencies must follow-up with beneficiaries regarding their application, and this might confuse some beneficiaries, particularly those who dealt solely with SSA in the application model.

**Exhibit 3.5**  
**SSA Field Office Staffing**

Sites By Model	Screening Staff	Field Office Application Staff	Screening Staff Backlog	Field Office Application Staff Backlog
<b>Screening Model</b>				
Carlisle, PA	3 SRs	NA	None	NA
Lebanon, PA	2 SRs	NA	None	NA
<b>Co-location Model</b>				
Oklahoma City, OK	8 SRs (1 new-hire, 1 bilingual)	NA	Long waiting times was an ongoing problem, 15–45 minutes to see receptionist, up to an hour to see an SR	NA
Muskogee, OK	1 Co-located worker	NA	Waiting time was 15–20 minutes, at the most, to see co-located worker.	NA
Uniontown, PA	1 Supervisor 1 Field office manager	NA	None	NA
West Chester, PA	5 SRs <sup>a</sup> (1 bilingual)	NA	None	NA
<b>Application Model</b>				
Miami, FL	3 SRs 3 Title II CRs	3 SRs 3 Title II CRs <sup>b</sup>		
Orlando, FL	22 SRs	25 Title XVI CRs	No backlogs at all; well staffed	No backlogs at all; extremely well staffed
Evansville, IN	8 Title XVI CRs and 1 detailee	8 Title XVI CRs and 1 detailee <sup>b</sup>	The field office noted that spikes in activity immediately following mailings “overwhelmed” the office at times.	Same as screening backlog
Lexington, KY	10 SRs	13 Title XVI CRs <sup>b</sup>	After a mailing, it took 3–4 weeks to return to pre-mailing workload.	During peak periods, application appointments had to be scheduled for future dates rather than done the same day as screening. Initially, the first available slot for call-ins was 10 days; when slots were added, backlog reduced to 5 days.

**Exhibit 3.5—Continued**

<b>Sites By Model</b>	<b>Screening Staff</b>	<b>Field Office Application Staff</b>	<b>Screening Staff Backlog</b>	<b>Field Office Application Staff Backlog</b>
<b>Application Model (cont.)</b>				
Corpus Christi, TX	<p>At the outset of demo: 2 SRs assigned to screening</p> <p>Revised at first mailing: all SRs (12)</p> <p>Over entire demo, SRs devoted about 10% of their time to Buy-in.</p>	<p>At outset of demo: 2 Title XVI CRs</p> <p>Revised at first mailing: All 12 Title XVI CRs to serve as back up.</p> <p>2 Title XVI CRs, both detailees, worked on alternating days exclusively on Buy-in. Other CRs in office helped out as needed.</p> <p>Field office lost detailees in August, but not a problem because Buy-in workload had trailed off.</p>	<p>At peak times, walk-in clients waited about 25 minutes to be screened.</p> <p>After a mailing, it generally took about 2 weeks for the workload to return to pre-mailing levels. It took longer after the first (largest) mailing.</p> <p>Over entire demo, SRs spent less than 10% of their time on Buy-in, but much higher directly after mailings.</p> <p>The demonstration disrupted SRs' workloads. The field office received more walk-in screenings than expected.</p>	<p>Demo particularly disrupted CRs' SSI workloads.</p> <p>Total overtime hours for the demonstration from 4/23/99 (first mailing) to 9/11/99 totaled 493 hours. Field office manager thought that CRs accounted for most of this time.</p>
Direct Service Unit	<p>25 Benefit authorization employees</p> <p>5 Bilingual SRs</p> <p>11 Benefit earnings techs</p>	NA	Volume high directly after a large mailing, beneficiaries more likely to get busy signal despite all staff working full time.	NA

Source: The Lewin Group interviews with state Medicaid liaisons.

### **III. STAFFING AT THE FIELD OFFICE, STATE MEDICAID AGENCY, AND DIRECT SERVICE UNIT**

*Exhibit 3.5* outlines the SSA staffing levels made in the screening, co-location, and application models by field office. For the application model, staffing is separated into screening and application tasks.

#### **A. Screening Model**

To conduct the screening, both Lebanon and Carlisle field offices relied on only two and three service representatives (SR), respectively. Claims representatives (CR) were used as back-ups in both offices.

The Carlisle SSA field office catchment area encompassed two counties, Cumberland and Perry, each with its own state Medicaid agency. The Cumberland County Medicaid agency organized the staffing responsibilities by assigning the scheduling tasks to one intake worker (the field office would call her number to schedule appointments) and having a back-up staff member when the intake worker was unavailable. Four appointments were scheduled per day, which the intake worker and two part-time trainees handled. The Perry County Medicaid agency, a smaller office, had three slots per day available for appointments, with one intake worker taking applications at one point. Cumberland County experienced an appointment backlog of approximately four weeks during peak period, but Perry County experienced no such difficulty.

Although the Lebanon field office had seven intake workers assigned to the demonstration, only half worked on the project on a given day and three were scheduled per day. Lebanon County also had a receptionist scheduling applications. The agency had experienced no difficulty with processing time requirements during The Lewin Group's site visit or follow-up calls.

#### **B. Co-location Model**

The co-location model operated in Oklahoma and Pennsylvania. Each state implemented the model in two locations: Muskogee and Oklahoma City, Oklahoma, and Uniontown and West Chester, Pennsylvania. As discussed in Chapter 1, Oklahoma already had one co-located state worker in each of the SSA field offices in Muskogee and Oklahoma City before the implementation of the Buy-in demonstration to encourage participation in CHIP. These workers also took applications for other Department of Children and Families programs (e.g., Buy-in, TANF, and food stamps). After the Buy-in demonstration was implemented, the co-located worker focused attention on Buy-in functions while continuing to take applications for CHIP and other state benefits. Thus, in these two locations, the demonstration did not substantially change the workers' daily responsibilities. In Pennsylvania, the co-located positions were newly created for this demonstration.

Although the Muskogee field office initially assigned screening responsibilities to four SRs, the co-located worker took on these responsibilities, in addition to his application responsibilities. This was a deviation from the model, which Chapter 6 discusses further. The Oklahoma City field office initially assigned seven SRs to handle screening, then hired a new SR during the



demonstration. The co-located worker in Oklahoma City was responsible for taking applications.

The West Chester field office had three SRs (one bilingual) and two development clerks assigned to perform screenings for the demonstration project. The development clerks were temporarily promoted to SRs for the duration of the demonstration. The Uniontown field office had one SR and one supervisor assigned to the screening function of the demonstration project.

The co-located worker in West Chester spent three days per week, from 9:00 A.M. to 12:30 P.M., at the field office. However, directly after a mailing, the co-located worker worked at the field office every day, from 9:00 A.M. to 4:00 P.M. to handle the increased volume. In Uniontown, the co-located worker was at the field office daily from 9:00 A.M. to 1:00 P.M. and had three appointments per day. The Uniontown County Medicaid agency used 17 rotating workers to serve as co-located workers because of union requirements.

### **C. Application Model**

The application model operated in five locations: Corpus Christi, Texas; Miami and Orlando, Florida; Lexington, Kentucky; and Evansville, Indiana. In general, if the SSA field office assigned specific employees to screening and application tasks, SRs were assigned to perform screenings and Title XVI (SSI) CRs were assigned to take applications.

Specifically, Corpus Christi had 12 SRs along with two Title XVI CRs detailed from other field offices, assigned to take applications. (The detailed staff alternated every other day; only one was at the Corpus Christi office on a given day.) Orlando's field office is the largest in the country. To handle the expected increase in volume, it assigned 20 SRs to perform screenings and 25 Title XVI CRs to take applications. Even with the increased staff, workers were spending an average of 16 hours per week on the Buy-in demonstration. In the Lexington office, 10 SRs were assigned to perform the screenings and 13 Title XVI CRs were assigned to take applications. In the Evansville field office, eight Title XVI CRs and one detailee were assigned both to perform the screenings and take the applications. The same staff member conducting the screenings would also handle application responsibilities. In the Miami field office, three SRs and three Title II CRs were assigned to conduct the screenings and take Buy-in applications. This practice was in contrast to that at the other application model field offices, where Title XVI CRs were taking Buy-in applications.

### **D. Widow(er)s Model**

Most of the field offices in Massachusetts did not assign specific staff to screen clients. Instead, most or all CRs and SRs were allowed to screen applicants. Several offices also trained clerical staff to screen clients.

The Massachusetts Medicaid agency used four MECs, but all Buy-in applications were reviewed and adjudicated in one MEC, in Tewksbury. The Tewksbury MEC had 57 workers responsible for fielding calls and adjudicating applications. Staff were not assigned specifically to the Buy-in demonstration.

## **E. Direct Service Unit**

Because the DSU would be screening most of the beneficiaries who inquired about the Buy-in, the center was well staffed. Forty-one employees in two locations worked in the DSU on the demonstration project. The first floor of the Security West Building housed 16 SRs and the seventh floor housed another 25 (5 bilingual). Many of the screeners previously worked as tele-service center representatives (that is, they answered calls to SSA's national toll-free information line).

To accommodate the fluctuation in volume, employees on the first floor of the Security West Building were assigned non-demonstration tasks on off-peak days. The employees on the seventh floor worked on the demonstration model full time, but filled off time with envelope-stuffing and other non-time sensitive tasks.

The hours of operation at the DSU were 6:30 A.M. to 7:30 P.M. Monday through Friday. Originally, it was thought that a West Coast state would be included in the demonstration, which is why hours were extended to 7:30 P.M. Volume, however, was low after 6:00 P.M.

## **IV. STAFF TRAINING**

*Exhibit 3.6* outlines the staff training on the screening process offered at the DSU and field offices and on the application process offered at the field offices participating in the application model.

### **A. Screening Program Training**

DSU and field office staff were trained on how to screen individuals who inquired about the Buy-in program, using a PC-based screening. At the outset of the demonstration, all screeners at the DSU underwent three full days of training on the screening tool, the Buy-in program, and the application scheduling process for the three different models for which they were to schedule applications. In contrast, screening staff in the demonstration field offices received a short amount of training on the screening tool, usually one to two hours, which was uniformly judged by staff as adequate. The screening staff at the field office needed to learn the application scheduling process specific to their field office only. All field offices found the screening tool easy to use and thought that the information required for conducting the interview was straightforward.

### **B. Application Training at the Field Office**

The state Medicaid agency provided training to the application site field offices. The state-trained field office staff on the application process, eligibility requirements, income and resource guidelines, and other state-specific requirements (e.g., covering evidence and verification requirements). Also, the state provided written training materials, which included information about the Buy-in program and copies of applications.

**Exhibit 3.6**  
**Field Office Staff Training**

Sites by Model	Screener Training			Field Office Application Training		
	Staff Trained	Duration	Trained By	Staff Trained	Duration	Trained By
<b>Screening Model</b>						
Carlisle, PA	All staff 3 SRs 7 Generalist CRs	2 hours	Field office manager	NA	NA	NA
Lebanon, PA	All staff 2 SRs 7 Generalist CRs	1½ hours	Field office manager	NA	NA	NA
<b>Co-location Model</b>						
Muskogee, OK	4 SRs Co-located worker	1 hour	Self	NA	NA	NA
Oklahoma City, OK	All staff 8 SRs 12 Title XVI CRs 2 Title II CRs	1 ½ hours	Field office general coordinator	NA	NA	NA
Uniontown, PA	1 SR 1 Supervisor	2 hours	Self	NA	NA	NA
West Chester, PA	All staff 5 SRs 6 Title XVI CRs 8 Title II CRs	1 hour	Field office manager	NA	NA	NA
<b>Application Model</b>						
Miami, FL	3 SRs 3 Title II CRs 1 Title XVI CRs Field Office systems staff	1 hour	Field office manager	3 SRs 3 Title II CRs	1 ½ hour	Medicaid agency
Orlando, FL	22 SRs 48 CRs (Title II and XVI)	40 minutes 1 hour	Field office systems staff	CRs (Title II and XVI)	40 minutes	Medicaid agency
Evansville, IN	8 Title XVI CRs and 1 detailee	10-20 minutes	Management support specialist	8 Title XVI CRs and 1 detailee	2 1-hour sessions	Medicaid agency

**Exhibit 3.6—Continued**

Sites by Model	Screener Training			Field Office Application Training		
	Staff Trained	Duration	Trained By	Staff Trained	Duration	Trained By
<b>Application Model (cont.)</b>						
Lexington, KY	10 SRs	2 hours plus reminder sessions	Field office systems staff	13 Title XVI CRs	2 hours	Medicaid agency; prepared special packet for SSA
Corpus Christi, TX	At outset: 2 SRs 2 Title XVI CRs Field office manager  Revised at first mailing: All 12 SRs	1 hour	Field office systems staff	At outset: 2 SRs 2 Title XVI CRs Field office manager  Revised at first mailing: All 12 Title XVI CRs	1 ½ hours	Medicaid agency
Direct Service Unit	25 Benefit authorization employees 5 Bilingual SRs 11 Benefit earnings techs	3 days	2 Operations staff	NA	NA	NA

Source: The Lewin Group interviews with SSA Field Office and Direct Service Unit staff.

All application model sites were using a short-form application, which made the application intake, and consequently the application training, easier. The duration of the training was based in part on how much experience staff had in taking applications. For example, Title XVI staff would already have a basic understanding of the Buy-in program before the demonstration because they take SSI applications, which is also a means-tested program.

Four of five application sites assigned Title XVI CRs to take applications, with Miami, Florida, being the only site that did not use Title XVI CRs for this purpose. The duration of application training was consistent at between one and one-half and two hours at four of five field offices. The Orlando, Florida field office had the shortest training time at 40 minutes for CRs. The Orlando training coordinator felt that staff already had adequate experience with the Buy-in program from their daily work with clients.

In light of the early missteps in the taking of applications by SSA staff, additional training might have been beneficial. For example, because they were not responsible for adjudication, SSA application staff were not trained on adjudication of applications. However, knowledge of adjudication requirements might have helped SSA application staff take more complete applications. In Corpus Christi, Texas, SSA application staff initially were unaware that the state accepted declaration and did not require verification for income and resources for SLMB and QI-1 benefits. As a result, they initially did not prompt applicants to supply bank and insurance information, causing the state Medicaid agency to have to follow up with the individual.

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## CHAPTER 4: OUTREACH

The success of the demonstration was contingent upon individuals learning about the program benefits and calling the Direct Service Unit (DSU) or the Social Security Administration (SSA) field office. Three of the four demonstration models used essentially the same approach for increasing awareness and screening Buy-in clients. The screening, co-location, and application models all employed periodic, targeted mailings to beneficiaries; posters; and the media to direct beneficiaries to either their local SSA field office or to the toll-free number at the DSU.<sup>21</sup> Each form of outreach was provided in English and Spanish.

The fourth model, for widow(er)s, relied on field office staff to identify appropriate clients from among the clients they would already see in the normal course of business. As originally conceived, it did not make use of the DSU, nor did it use outreach letters.

This chapter is divided into two sections; the first addresses the targeted mailings while the second outlines additional outreach. A table detailing outreach activities, by site, is located at the end of this section (*Exhibit 4.14*). Finally, deviations from the originally intended model design and staff suggestions for improvement are described.

### I. SOCIAL SECURITY ADMINISTRATION MAILINGS

As noted in Chapter 2, a letter recipient file was extracted from the Master Beneficiary Record (MBR) to determine which individuals would be sent an outreach letter for the demonstration. A total of 239,110 letters were mailed.

#### A. Timing and Volume

Starting in March 1999, letters were sent to potential participants living in selected zip codes who met the following criteria:

- Single and received individual monthly Title II Social Security benefits of less than \$947 or married and had combined benefits of less than \$1,265 (equivalent to 135 percent of the poverty guideline plus the \$20 income disregard);<sup>22</sup>  
-AND-
- Received Medicare Part A benefits; *or*
- Attained the age of 64 and 11 months or had received at least 24 consecutive months of disability insurance benefits.

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<sup>21</sup> The outreach letter also invited beneficiaries to contact their local state welfare, social services, or medical assistance office, but it was expected that most would either call the DSU or visit their local SSA field office, which is usually much more familiar to the beneficiary.

<sup>22</sup> The first four mailings used the 1998 lower cut-offs for identification of potential Buy-in participants. Potential letter recipients during these mailings included single recipients who received monthly Title II benefits of \$926 per month or less and married couples receiving \$1,241 or less. The June 1999 mailing captured those who should have been included in the previous few mailings. All subsequent mailings used the 1999 threshold outlined.

The 239,110 letters were sent, staggered in nine separate batches according to the terminal digit of the recipient's Social Security number (SSN) and demonstration model.<sup>23</sup> SSA sent the first batch of letters on March 17 to beneficiaries living in the screening model communities (Carlisle and Lebanon, Pennsylvania). The second batch, mailed on April 8, included beneficiaries living in the co-location model areas as well as the screening model areas. Individuals living in the application model areas began receiving letters with the April 23 mailing. *Exhibit 4.1* presents the number of letters sent by mailing date and model.

The letter informed the targeted Medicare beneficiaries that programs were available to help them pay Medicare costs. Letters in Spanish were sent to Medicare beneficiaries who had previously indicated a preference to receive SSA information in Spanish. Individuals who met the income and resource limits were advised to call a toll-free telephone number between 6:30 A.M. and 7:30 P.M. Monday through Friday. Bilingual DSU employees were available to screen callers who preferred Spanish. An SSA worker was available to answer any questions they had. Also, the letter informed them that if they preferred, they could visit their local welfare, medical assistance, or Social Security office.<sup>24</sup>

By the third batch, letters were being sent to individuals living in the screening, co-location, and application model areas, resulting in an increased volume of telephone calls to the DSU as well as to the field offices. In the third mailing the number of letters sent had nearly doubled compared with the second mailing. SSA added three additional mailing dates to the original schedule to spread the remaining letters across more mailings and produce a more manageable number of calls to the DSU. As *Exhibit 4.1* shows, SSA sent fewer letters starting June 7, 1999.

### Exhibit 4.1

#### Number of Letters Sent to Medicare Beneficiaries, by Model and Date

Mailing Date	Screening	Co-location	Application	Total by Mailing Date
March 17	8,164	0	0	8,164
April 8	8,111	16,393	0	24,504
April 23	5,521	16,457	24,302	46,280
May 14	5,470	16,379	24,002	45,851
June 7	895	10,726	14,353	25,974
June 21	0	8,679	12,536	21,215
July 12	0	8,657	12,371	21,028
July 22	0	8,656	12,461	21,117
August 9	0	0	24,977	24,977
<b>Total</b>	<b>28,161</b>	<b>85,947</b>	<b>125,002</b>	<b>239,110</b>

Source: The Lewin Group interviews with SSA central office staff.

Letters to beneficiaries were the principal form of outreach used in all demonstration sites, aside from the widow(er)s model sites. SSA field offices in these locations also were encouraged to

<sup>23</sup> SSA originally scheduled six mailings.

<sup>24</sup> For a copy of the letter sent to Medicare beneficiaries, see Appendix A.



engage in other outreach activities they thought appropriate and were provided pamphlets, posters, and public service announcements. The widow(er)s model did not use targeted letters to inform widow(er)s about the demonstration but instead relied on field office staff to identify appropriate clients as they encountered them throughout the normal course of business.

## B. Characteristics of Intended Letter Recipients

Those who were sent a letter informing them of the Buy-in program were mostly women in their late 60s or early 70s. **Exhibit 4.2** shows the breakdown by sex and benefit status of the entire sample and reveals that nearly two-thirds of the intended recipients were female and only a small portion of intended letter recipients (fewer than 3 percent) were married. Both received benefits based on the primary claimant (i.e., 150 percent of the primary monthly benefit). This might largely be a result of the fact that many married couples have separate claims.

**Exhibit 4.2**

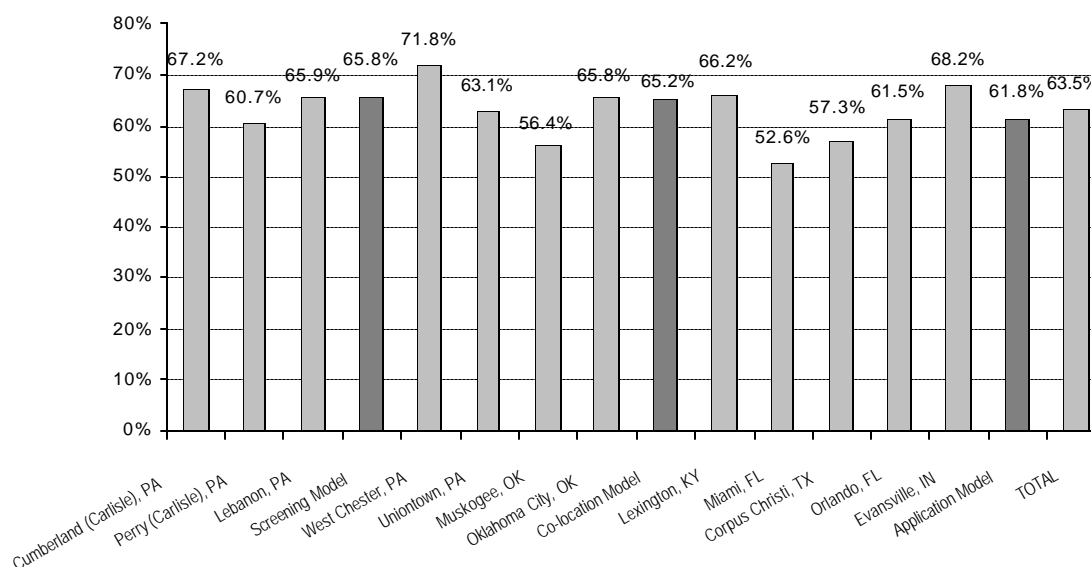
### Distribution by Sex and Benefit Status among Those Sent a Letter

Sex	Frequency	Percent	Benefit Status	Frequency	Percent
Male	87,327	36.5%	150% of Primary	6,921	2.9%
Female	151,738	63.5%	Primary Only	232,189	97.1%
Total	239,110	100.0%	Total	239,110	100%

Source: The Lewin Group tabulations of Master Beneficiary Record data.

**Exhibit 4.3**

### Percentage of Letters Distributed to Females, by Site and Model

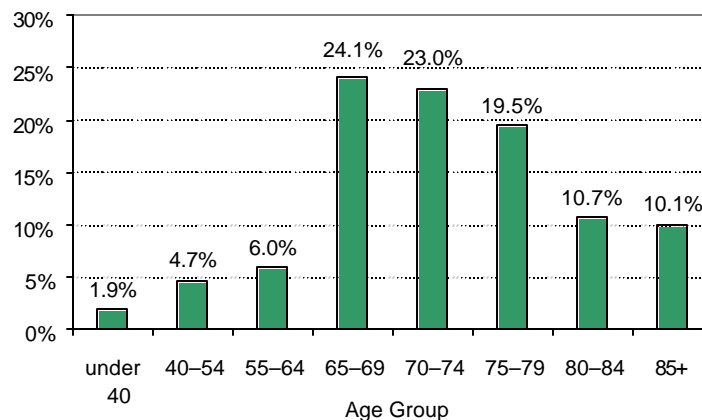


Source: The Lewin Group tabulations of Master Beneficiary Record data.

As indicated in **Exhibit 4.3**, although a majority of the primary beneficiaries were female, in some regions, Miami, Florida in particular, the sample was more evenly distributed between men

and women, as 52.6 percent of letters were delivered to females. On average, the screening and co-location models distributed a larger percentage of letters (65.8 and 65.2 percent, respectively) to women than did the application model (61.8 percent).

**Exhibit 4.4**  
**Percentage of Letters Sent by Age Group**



Source: The Lewin Group tabulations of Master Beneficiary Record data.

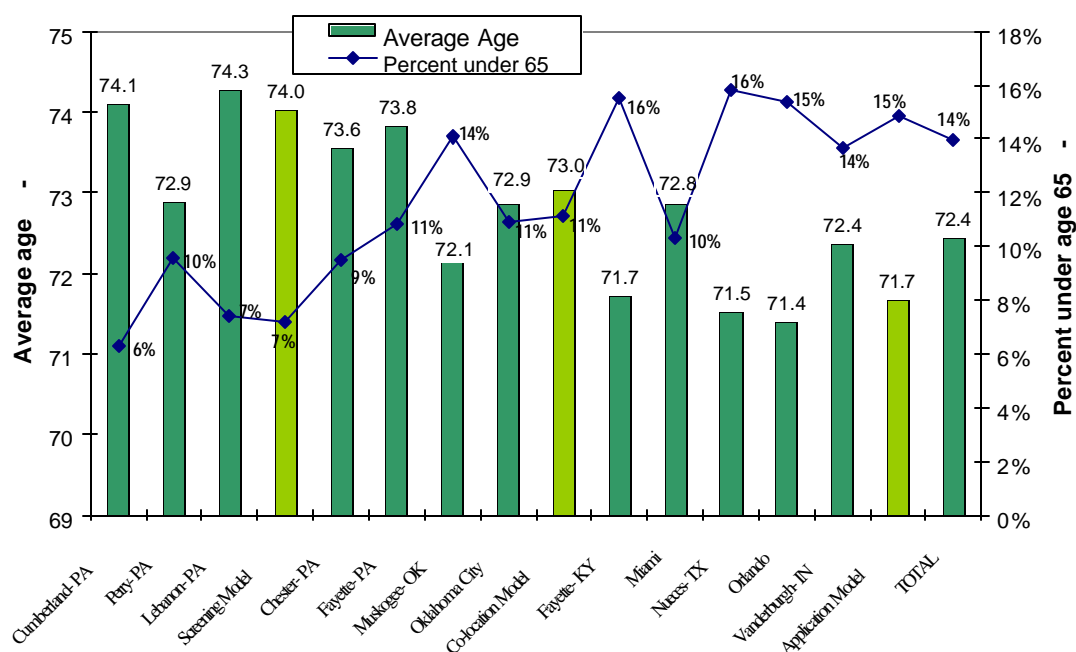
The age distribution ranged from 10 years to 110 years of age. *Exhibit 4.4* illustrates the distribution of letters sent by age group. Nearly half of the sample was between the ages of 65 and 74 while around 13 percent of the sample was under age 65. A small portion of the group (1.9 percent) was under the age of 40.

*Exhibit 4.5* depicts the average age of the sample by site with the percentage of intended letter recipients under age 65. The average age for intended letter recipients across all sites was 72.4 years. Pennsylvania residents who were sent letters were older on average while residents in Orlando, Florida; Corpus Christi, Texas; and Lexington, Kentucky (sites in the application model) were, on average, slightly younger. Lebanon, Pennsylvania, and Orlando, Florida, represent the two extremes with average ages of 74.3 years and 71.4 years, respectively.

Because those in the application model sites were younger, on average, it would follow that they, too, were more likely to be under age 65, compared to the other models. Corpus Christi Texas; Lexington, Kentucky; and Orlando, Florida, all had at least 15 percent of intended recipients who fell into this category. The screening model sites had the highest average age (74 years) and the lowest percent under age 65 (7.2 percent).

## Exhibit 4.5

## Average Age and Percentage of Intended Letter Recipients under Age 65, by Site and Model

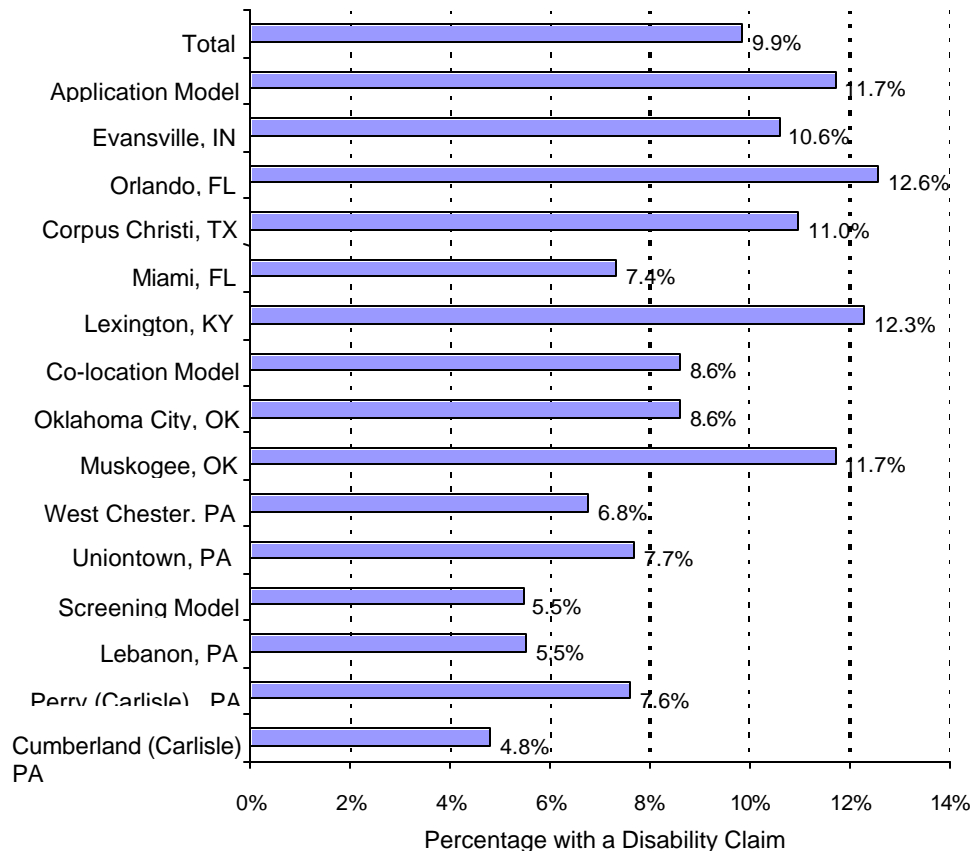


Source: The Lewin Group tabulations of Master Beneficiary Record data.

As shown in *Exhibit 4.6*, the percentage of intended letter recipients with a disability claim varied by site and also by model. While those in the application model tended to be younger, it follows that they were also more likely to have a disability claim than the sites in the screening and co-location models.<sup>25</sup>

<sup>25</sup> We would have expected the percentage under age 65 and the percentage with a disability claim to be more similar. We are investigating this further.

**Exhibit 4.6**  
**Percentage of Intended Letter Recipients with a Disability Claim,**  
**by Site and Model**



Source: The Lewin Group tabulations of Master Beneficiary Record data.

Additional characteristics of the intended letter recipients were determined through the Primary Insurance Amount (PIA) and the Monthly Benefit Payable (MBP) amounts. The averages for these figures are calculated, by site and model, in *Exhibit 4.7*.

The PIA is based on a person's average indexed monthly earnings. It is used to determine the monthly Title II benefit amount and reflects the recipient's earnings history and, in turn, socioeconomic status. The PIA is subject to reduction for early retirement. The PIA was highest in Uniontown, Pennsylvania, indicating that these intended letter recipients likely had higher lifetime earnings, on average, than their counterparts in the other demonstration sites. Intended recipients in Miami, Florida, on the other hand, averaged the lowest PIA, indicating that they likely earned less, on average. Evansville, Indiana, and four of the five Pennsylvania sites, had a PIA higher than the average across all sites.

**Exhibit 4.7****Average Social Security Benefits, Calculated by Site and Model, for Intended Letter Recipients**

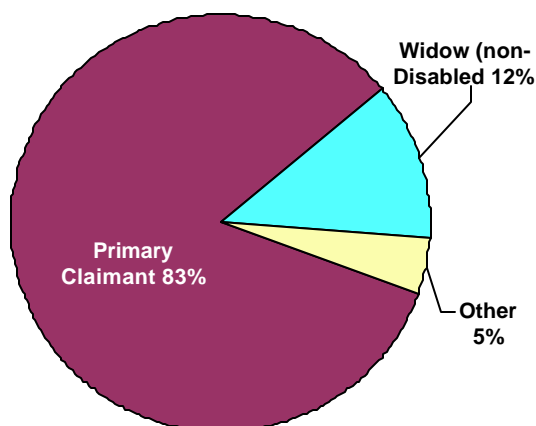
	Site	Average PIA	Average MBP
<b>SCREENING</b>	Cumberland County (Carlisle), PA	\$689	\$590
	Perry County (Carlisle), PA	704	591
	Lebanon County, PA	715	620
	<b>Screening Model</b>	<b>703</b>	<b>603</b>
<b>CO-LOCATION</b>	Uniontown, PA	747	624
	West Chester, PA	725	631
	Muskogee, OK	681	582
	Oklahoma City, OK	679	581
	<b>Co-location Model</b>	<b>700</b>	<b>600</b>
<b>APPLICATION</b>	Lexington, KY	677	587
	Miami, FL	629	544
	Corpus Christi, TX	683	576
	Orlando, FL	699	603
	Evansville, IN	723	631
	<b>Application Model</b>	<b>692</b>	<b>597</b>
	<b>Total</b>	<b>697</b>	<b>599</b>

Source: The Lewin Group tabulations of Master Beneficiary Record data.

Average MBP amounts are calculated in the final column of *Exhibit 4.7*. The MBP identifies the monthly Title II benefit due to the beneficiary after the collection of some or all of the beneficiary's obligations. Because this amount is related to the PIA, it is not surprising that Miami, Florida, remained at the low end of the value range while Evansville, Indiana; Perry County, Pennsylvania; and Uniontown, Pennsylvania, maintained the highest averages for this measure. The average PIA and MBP amounts varied only slightly between sites and were nearly equivalent across models.

The MBR provides information concerning beneficiary status through the Beneficiary Identification Code (BIC). The BIC distinguishes between those who are primary claimants and those who are second-, third-, or higher-order claimants. It also identifies characteristics such as marital status, age, and disability status and clusters people into mutually exclusive groups. This variable reveals that a majority of those sent an outreach letter (83 percent) were primary claimants (*Exhibit 4.8*). The next largest group (12 percent) is comprised of non-disabled widows (of various claimant levels and current marital status).

**Exhibit 4.8**  
**Beneficiary Status of Intended Letter Recipients**



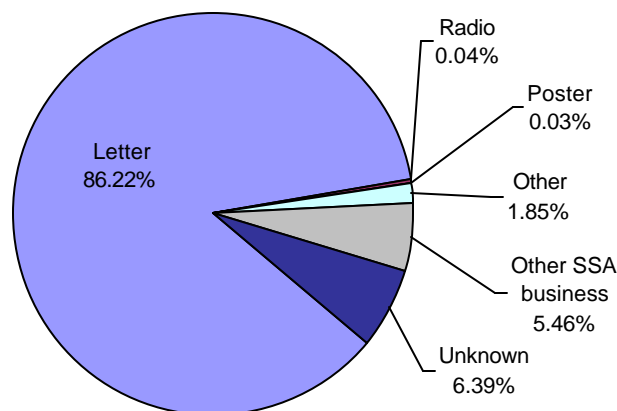
Source: The Lewin Group tabulations of Master Beneficiary Record data.

### C. Response to the Outreach Letter

In all sites where SSA used targeted letters to reach potential clients, the letters were considered by far to be the most effective form of outreach. Several DSU and field office workers explained that seniors tend to take letters from SSA seriously and that many contacted the field office or called the DSU before even reading the letter to find out what it meant.

The screening data confirm that a large majority of those screened heard about the program through the SSA mailing letter (*Exhibit 4.9*).

**Exhibit 4.9**  
**How Screened Individuals Learned about the Buy-in Program**



Source: The Lewin Group tabulations of screening data.

Approximately 86 percent reported the letter from SSA as the source through which they had heard about their potential eligibility, and it is likely that a large portion of those who failed to indicate how they learned of the program also received a letter (see discussion of the MBR data match in Chapter 2). More than five percent of the sample learned about the program through other business with SSA, while only a handful of people indicated that they had heard about the program through radio ads or posters.

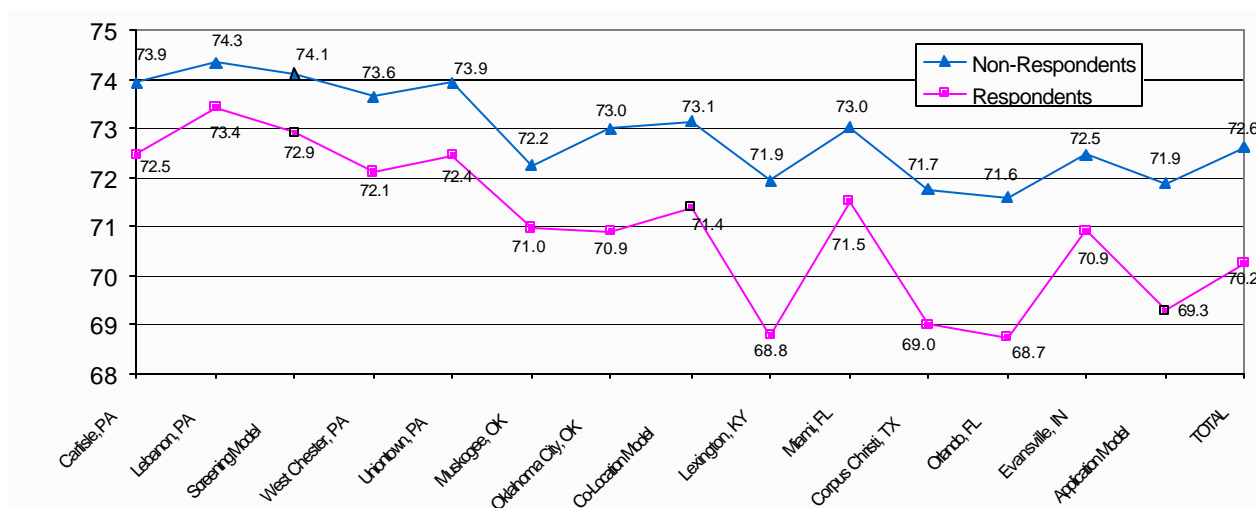
Fewer than one-tenth of one percent of all screening records noted more than one method by which individuals learned about the program. In instances where two reasons were given, only one reason was documented. Individuals who received a letter are contained in the 86.22% figure, despite the fact that a few of them heard of the Buy-in program by methods other than a letter. For individuals who heard of the program via a concrete method (i.e., poster, radio, and other business with SSA) and also by “other” means, the more concrete method was documented. A few people heard of the program through the radio or a poster and also through other SSA business. These people were categorized under radio or poster, respectively.

The matched screening and MBR data allowed us to look at additional characteristics of screened participants such as sex, age, and socioeconomic status (using the PIA and monthly Title II benefit amount) while also enabling the comparison of these characteristics between respondents and non-respondents.

In general, the percentage of males and females did not vary based on response versus non-response to the outreach letter. Sixty-three percent of respondents were female while 63.5 percent of non-respondents were female.

**Exhibit 4.10**

**Average Age for Non-Respondents and Respondents, by Site and Model**



Source: The Lewin Group tabulations of matched screener and Master Beneficiary Record data.

**Exhibit 4.10** shows the average age for those screened (respondents) and for those who were sent letters and did not get screened (non-respondents). Unlike sex, the age of intended letter recipients varied depending on their response or lack thereof. Those who responded were

younger, on average, than non-respondents in all sites. The age discrepancy between the two groups was greatest in Lexington, Kentucky; Orlando, Florida; and Corpus Christi, Texas, where non-respondents were, respectively, 3.1 years, 2.9 years, and 2.8 years older, on average.

The difference was very small in Lebanon, Pennsylvania (0.9 years). Thus, age differences were greatest in the application model (2.6 years) and smallest in the screening model (1.2 years). The average age difference in the co-location model was 1.8 years.

The PIA was also compared between non-respondents and respondents. As outlined in *Exhibit 4.11*, average PIA values vary little by site.

#### Exhibit 4.11

##### Average Primary Insurance Amounts for Non-Respondents and Respondents, by Site and Model

Site	Non-Respondent PIA	Respondent PIA	Difference
Carlisle, PA	\$692.25	\$702.57	-\$10.32
Lebanon, PA	\$715.30	\$714.22	\$1.08
Screening Model	\$702.68	\$707.91	-\$5.23
Uniontown, PA	\$748.02	\$733.86	\$14.16
West Chester, PA	\$725.45	\$730.13	-\$4.68
Muskogee, OK	\$681.47	\$673.66	\$7.81
Oklahoma City, OK	\$678.86	\$679.97	-\$1.11
Co-location Model	\$700.88	\$696.64	\$4.23
Lexington, KY	\$677.91	\$674.56	\$3.35
Miami, FL	\$630.95	\$615.06	\$15.89
Corpus Christi, TX	\$682.40	\$690.57	-\$8.17
Orlando, FL	\$701.08	\$681.14	\$19.93
Evansville, IN	\$724.12	\$707.14	\$16.97
Application Model	\$693.88	\$678.59	\$15.29
<b>Total</b>	<b>\$697.51</b>	<b>\$686.58</b>	<b>\$10.93</b>

Source: The Lewin Group tabulations of matched screening and Master Beneficiary Record data.

The greatest discrepancy occurred in Orlando, Florida, where average PIA for non-respondents was \$19.93 higher than that of respondents. This difference was least distinguishable between the two groups in Lebanon, Pennsylvania where the difference was \$1.08. With respect to model, the difference ranged from -\$5.23 in the screening model to \$15.29 in the application model.

The difference in the average PIA of non-respondents and screened individuals across sites was often positive. This indicates that some of those who received SSA mailing letters might have known that their higher incomes would preclude their participation in the Buy-in program.

In addition to examining PIA, Title II income as a percentage of the federal poverty guideline was compared (see *Exhibit 4.12*).



**Exhibit 4.12****Title II Income as a Percentage of the Federal Poverty Guideline**

Percent of Poverty	Respondents	Non-Respondents
< 50%	6.5 %	8.5%
50%–100%	49.3	47.9
101%–120%	28.8	24.7
121%–135%	15.5	18.9
Total	100.0%	100.0%

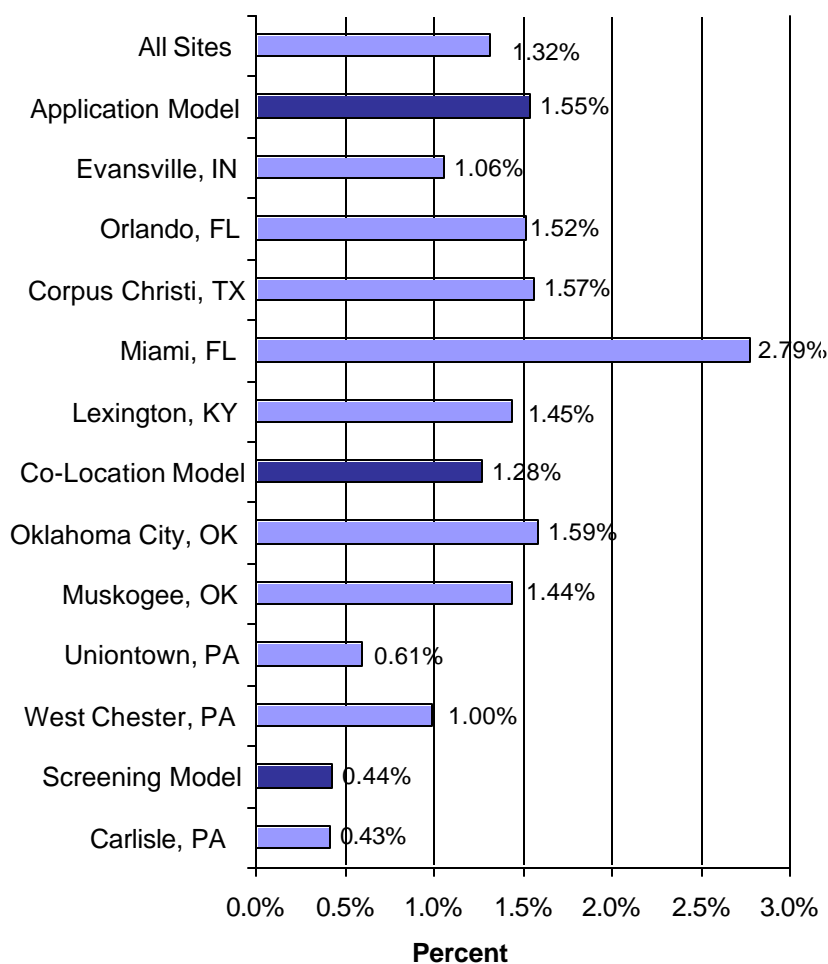
Source: The Lewin Group tabulations of matched screening and Master Beneficiary Record data.

This analysis indicates that this income source, as a percentage of the poverty guideline, varied little between respondents and non-respondents: 55.8 percent of respondents compared to 56.4 percent of non-respondents fall at or below 100 percent of the poverty guideline. Although, the highest income group, and therefore the group most likely to have other income sources that would disqualify them for eligibility, had the largest difference between non-respondents and respondents (3.4 percentage points).

**D. Returned Letters**

The returned letter statistics suggest that the vast majority of outreach letters reached their intended destination. Across all three models using outreach letters, approximately 1.3 percent of the letters (3,157) were returned. The overwhelming reason for the return was that the letters were “undeliverable” (99 percent). This nebulous reason was accompanied by no additional explanation. It was rare that a specific reason, such as “death” or “ineligible,” was indicated. As illustrated in *Exhibit 4.13*, a larger percentage of letters were returned in the application model sites than in the other models. The site with the highest returned letter rate was, by far, Miami, Florida with a 2.8 percentage returned rate. This site contains a large Hispanic population and is among the poorest of all 12 sites.

**Exhibit 4.13**  
**Percentage of Letters Returned by Site**



Source: The Lewin Group tabulations of undelivered letter data.

## II. OTHER OUTREACH EFFORTS

In many sites where letters were used, activity generated by the letters kept staff busy enough that they saw little or no need to do additional outreach. Nevertheless, most field offices reported having done some outreach at the beginning of the demonstration period. Outreach activities included giving presentations to senior groups, putting up posters in senior centers and in the Office of Aging, submitting press releases to newspapers, conducting radio interviews, and attending health fairs.

**Exhibit 4.14** summarizes outreach activities at each field office. The text describes common outreach efforts.

**Exhibit 4.14**  
**Outreach Activities**

Field Offices by Model	Posters outside Field Office	Media	Other SSA Outreach	Non-SSA Outreach
<b>Screening Model</b>				
Carlisle, PA (Perry and Cumberland Counties)	<ul style="list-style-type: none"> <li>• Senior centers</li> <li>• Office of Aging</li> </ul>	<ul style="list-style-type: none"> <li>• None, newspaper not cooperative</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Lebanon, PA	<ul style="list-style-type: none"> <li>• Office of Aging</li> <li>• Human Service Counseling</li> <li>• Hospitals and pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>• Two radio Q and A shows in Spanish</li> <li>• Press release in local newspaper</li> </ul>	<ul style="list-style-type: none"> <li>• Booth at local health fair</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Co-location Model</b>				
Muskogee, OK	<ul style="list-style-type: none"> <li>• Office of Veterans Affairs</li> <li>• Senior centers</li> <li>• Nutrition sites</li> </ul>	<ul style="list-style-type: none"> <li>• None, newspaper not cooperative</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Co-located worker in Muskogee since 10/98 for CHIP outreach</li> </ul>
Oklahoma City, OK	<ul style="list-style-type: none"> <li>• Department of Health Services</li> <li>• Restaurants that offer reduced price lunch to seniors</li> </ul>	<ul style="list-style-type: none"> <li>• Press releases in the newspapers</li> <li>• Public service announcements on the radio</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Co-located worker in Oklahoma City since 10/98 for CHIP outreach</li> </ul>
Uniontown, PA (Fayette County)	<ul style="list-style-type: none"> <li>• Senior citizen and state agency booths at county fair</li> </ul>	<ul style="list-style-type: none"> <li>• Two Q and A radio programs</li> <li>• Press releases to two newspapers</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
West Chester, PA (Chester County)	<ul style="list-style-type: none"> <li>• Senior citizen centers</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Discussion with local congressman</li> <li>• Visit to Office of Aging, discussion with advocates and intake workers</li> <li>• Visit to Office of Mental Retardation</li> <li>• Presentation at Community Service Council</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

Exhibit 4.14 - *continued*

Field Offices by Model	Posters outside Field Office	Media	Other SSA Outreach	Non-SSA Outreach
<b>Application Model</b>				
Miami, FL	<ul style="list-style-type: none"> <li>Post Office</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Educating staff of Little Havana Activity Center (Spanish speaking senior center) about Buy-in</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Orlando, FL	<ul style="list-style-type: none"> <li>State Division of Children and Family Services</li> </ul>	<ul style="list-style-type: none"> <li>Press releases to local radio, newspapers, and television, including Spanish news media</li> </ul>	<ul style="list-style-type: none"> <li>Developing list of Hispanic groups and contacting their reps</li> <li>Discussion of Buy-in programs in group speaking engagements</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Evansville, IN (Vanderburgh County)	<ul style="list-style-type: none"> <li>Council of Aging</li> <li>State Division of Families and Children</li> </ul>	<ul style="list-style-type: none"> <li>None because the media outreach is broader than the demo area.</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Lexington, KY (Fayette County)	<ul style="list-style-type: none"> <li>Churches</li> <li>Post Office</li> <li>Grocery stores</li> <li>Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Radio announcements</li> </ul>	<ul style="list-style-type: none"> <li>Mentions at various councils (e.g., social worker groups, hospital staff groups, Council on Aging) and at senior citizen centers.</li> <li>Discussions with employee groups on retirement issues</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
Corpus Christi, TX (Nueces County)	<ul style="list-style-type: none"> <li>Post Office</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>Posters to contact stations and educational materials to requesting groups</li> </ul>	<ul style="list-style-type: none"> <li>HCFA mailing</li> </ul>

Source: The Lewin Group interviews with SSA field offices.

## **A. Posters and Brochures**

Posters and brochures<sup>26</sup> were distributed to all field offices to display on-site as well as to distribute to places frequented by seniors. Both were available in English and Spanish. The posters and brochures gave basic information about the program and recommended that individuals call the toll-free number to find out if they might qualify for the benefits.

All field offices put up posters and brochures on-site. Common places where posters were put up outside the field office (three or more field offices) were senior centers, offices of aging, local Medicaid agencies, and post offices.

One field office reported that post offices and grocery stores would not allow them to put up posters. Field office staff in this field office thought that, in general, posters were not an effective way to educate potential applicants because seniors are heavily marketed to and are distrustful of promises of benefits. At another field office, a staff member commented that many seniors do not often leave their homes, making it unlikely that they will see a poster or pick up a brochure. However, posters might be an effective way to educate the children of seniors, who might in turn urge their parents to apply.

## **B. Media and Publicity**

Publicity was left to each field office. SSA created several public service announcements for the radio and information for the print media that field offices could obtain if interested. In addition, the field offices could contact their local newspapers, local television networks, and other outlets to publicize this demonstration.

In addition to public service announcements and press releases in local newspapers, two field offices had question and answer shows on the radio. In Lebanon, Pennsylvania, where there is a large Puerto Rican community, the radio show was held in Spanish. The Orlando, Florida field office, which also has a large Hispanic community, ran Spanish press releases in the news media. In contrast, the Evansville, Illinois field office chose not to use media outreach, because they were concerned that this outreach might spill into non-demonstration areas. Two field offices reported that the local newspaper was uncooperative.

## **C. Other Social Security Administration Outreach**

In addition to posters and media, some field offices engaged in other outreach activities. Some field offices in areas with large Hispanic communities engaged in outreach directed at the Hispanic community. The Miami, Florida field office educated the staff at Little Havana Activity Center (senior citizen center) about Buy-in benefits. The Orlando, Florida field office developed a list of Hispanic groups and contacted their representatives. The Lebanon, Pennsylvania field office participated in two radio question and answer shows in Spanish.

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<sup>26</sup> See Appendix B for a copy of the brochure.

Most field offices also cited word-of-mouth as another source of information from which clients reported learning about the Buy-in program.

#### **D. Model-Specific Identification of Clients**

As described above, the SSA central office identified potential Buy-in clients in the screening, co-location, and application sites and sent these individuals outreach letters.

In contrast to the other three models, the widow(er)s model field offices in Massachusetts were themselves required to identify appropriate clients. Outreach activities in this model underwent several modifications during the course of the demonstration. Chapter 3 discusses the chronology of these changes. Initially, SSA staff were required to identify clients among those with whom they would have already had contact even without the demonstration, most likely to change their benefit status because of the spouse's death. This resulted in a low volume of appropriate clients to screen. The lack of activity under this model made Buy-in screening an exception to the daily routine.

As a result of the low volume, some field offices started using funeral director death report forms to identify recent widow(er)s and contact appropriate clients for screening. This practice became official policy in July 1999. In September 1999, field offices were instructed to send outreach letters to clients identified through funeral director death report forms, rather than to contact them directly.

### **III. STAFF SUGGESTIONS FOR IMPROVEMENT**

Field office staff had opinions about which outreach efforts appeared to be the most effective as well as how they could be improved. The SSA outreach letter was unanimously thought to be the most effective form of outreach. Nevertheless, staff had suggestions for improvement to the mailing process.

Staff at all field offices noticed sharp spikes in their demonstration activity two days after each mailing (see *Exhibits 5.1 and 5.2* in the discussion of the screening process in Chapter 5). Because of the spikes in activity directly following a mailing, several field offices suggested spreading the mailings out into smaller, more frequent mailings. Demonstration staff adopted this approach for the final mailings, splitting two large mailings into five smaller ones.

The original schedule of mailings also created problems for the state agencies, especially in the screening model sites. Although states are used to having a backlog of Buy-in program applications because of the amount of time and effort required for adjudication, they are required by law to process applications within a specified number of days. The standard varies by state, but is commonly between 30 and 45 days. Thus, the large inflow of applications created an acute administrative burden in some of the state agencies.

Along with suggestions about the mailing, field and state agency staff in several sites had suggestions for improving the outreach letter itself. Suggestions include the following:

- Several screeners at the DSU and at two field offices in the models where outreach letters were sent thought that the letter did not adequately define resources. One screener suggested

that the letter might be clearer if it provided some examples (e.g., stocks, and bonds) and if it emphasized that resources included the spouse's resources.

- Two field offices suggested that the beneficiary's SSN should be on the letter. This might be impossible if a contractor mails the letters because of confidentiality issues.
- A co-location model field office suggested that the beneficiary's telephone number should be on the appointment letter. This field office spent a lot of time rescheduling applicants initially scheduled by the DSU. This would require the addition of this field on the PC screening tool.
- A screening model state Medicaid agency suggested that having the letter come jointly from SSA and the state would alert people up front that the welfare department was involved. The state Medicaid staff at this site spent a great deal of time explaining to individuals why they must apply at the state agency and not the SSA field office. Such a practice would have required additional initial coordination and letters tailored for each state; however, it might have reduced the high no-show rate experienced in the screening model.
- Field offices across states reported that some clients were concerned that accepting Buy-in benefits could allow the federal or state government to take their house away, engage in estate recovery after the client dies, or disqualify them for other benefits. One suggestion was that the outreach letter should try to allay these fears to the extent possible. To make such a statement, and ensure its activity, a complete review of program eligibility at both the state and federal levels would be required.

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## **CHAPTER 5: SCREENING**

This chapter is divided into four sections. Section I provides an overview of the screening process. Next, Section II explores basic screening process outcomes including screening time, response to the outreach (as evidenced by percent of screens), and differences in screens between the Direct Service Unit and field offices. Section III delineates the characteristics of those screened. Finally, Section IV discusses departures from the original demonstration design.

All statistics presented in this chapter were calculated using the set of screenings conducted through December 31, 1999. Information drawn from a matched MBR–screening data set complement these statistics because, as described in Chapter 2, some demographic information that was included in the Master Beneficiary Record (MBR) was unavailable in the screening data.

### **I. SCREENING PROCESS**

After Medicare beneficiaries called the toll-free number listed on the letters, posters, and brochures or visited their local field office, they were screened by a staff member using a simple PC-based program designed to quickly assess the individual's income and resources, thereby determining potential eligibility.<sup>27</sup> Screenings were performed over the phone for those who called the DSU and in person for individuals who visited the field office.

The following steps were to be taken during the screening process:

1. Medicare beneficiaries inquired about their eligibility for programs that help pay Medicare costs.
2. The interviewer read the Privacy and Paperwork Reduction Act Notice to the caller.<sup>28</sup>
3. The interviewer asked for basic client identification and entered the information into the screener tool (e.g., Social Security number [SSN], first and last names, address). If the individual lived outside the demonstration area, he or she was told to call the national toll-free telephone number (not the DSU) or contact the local Medicaid agency for more information. For these individuals, the interview was terminated.
4. For individuals living in applicable areas, the screening continued, and the interviewer confirmed that the individual was receiving Medicare Part A. If the individual were not, the screening was terminated, and no letter was generated. The interviewer informed the individual that he or she was not eligible for the Buy-in program.
5. Next, the interviewer confirmed that the individual was not receiving Premium Part A for working individuals; again, if the individual were receiving this benefit, the screening was

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<sup>27</sup> Appendix C provides a copy of the screening tool.

<sup>28</sup> Appendix D includes a copy of the Privacy and Paperwork Reduction Act Notice.

terminated, and the individual received no letter. The interviewer informed the individual that he or she was not eligible for the Buy-in program.

6. For those individuals whose screening continued, the interviewer requested information on Title II benefits. If the client were single and had Title II income greater than or equal to \$947 or was married and had Title II income greater than or equal to \$1,265, the screening was automatically terminated; he or she was asked no further questions regarding resources and other income. These values defaulted to zero. The individual received a denial letter indicating that he or she was likely ineligible but could follow-up with the local Medicaid agency to confirm this.
7. For those having Title II income below the cut-off level, the interview continued with questions regarding resources. If total, countable resources were above the limits (\$4,000 for a single beneficiary, \$6,000 for a married couple), the interview was terminated, and the individual received a denial letter. Otherwise, the screening continued with more detailed income questions.
8. If the individual's income and resources were below the established limits, he or she would receive an appointment letter. The letter included the individual's income and resources, by source, with a specified appointment date and time. If an appointment could not be scheduled at the time of the screening, the letter informed the individual of the need to schedule an application appointment.

In counting income and resources for Qualified Medicare Beneficiary (QMB) applicants, the states must not use a more restrictive set of criteria than defined by the federal government (and outlined above). However, states have the flexibility to be less restrictive and disregard more income or resources than is set by the federal government. This is also true for Specific Low-Income Beneficiary (SLMB) benefits. For example, Florida's resource limits are \$5,000, rather than \$4,000, for single individuals. As a result, the screener could be screening out some individuals who are, in fact, eligible by state standards. The PC software program was designed to be used for all models in all states, even though states could have different income and resource requirements. SSA justified this in two ways: The speed with which the demonstration had to be implemented precluded specialized variations of the screening tool; and if SSA were ever charged with administering Buy-in applications, one income and resource limit would be used.

Some individuals who passed the screening were later determined ineligible for benefits. This generally occurred when an individual failed to report all income and resources to the interviewer but reported this information when filling out the more detailed application form. Also, states require some evidence and/or verification of income and resources, the inclusion of which was not feasible with the PC-based screening tool.

## **II. PROCESS-RELATED OUTCOMES**

The data available permit cross-tabular analyses of 1) the timing following a mailing and volume of screenings, 2) the amount of time to conduct screenings, 3) the response rate to the outreach letters, and 4) the distribution of screenings between the DSU and field offices.

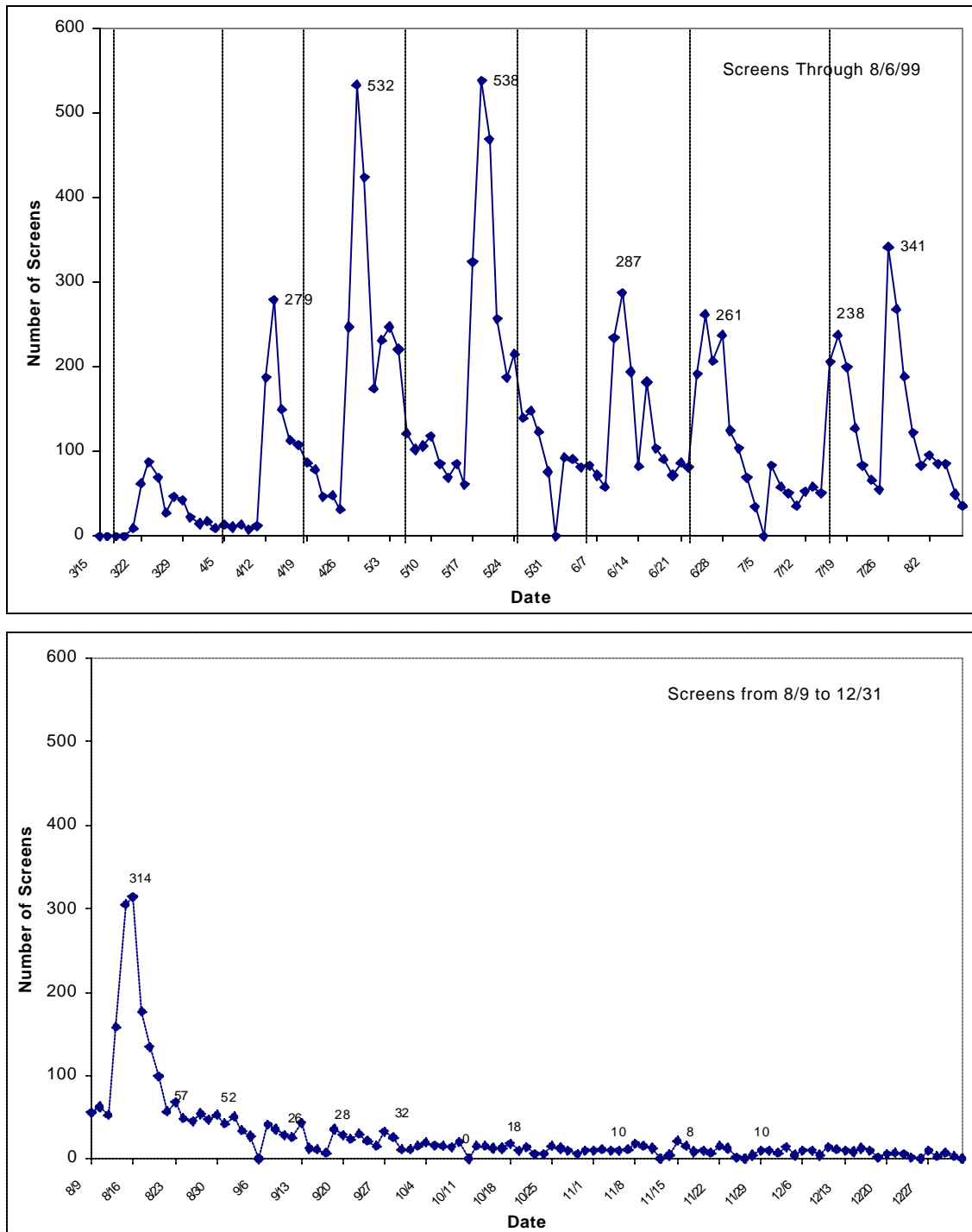
## A. Timing and Volume

Screening data confirm that screening activity spiked directly following each outreach letter mailing. *Exhibit 5.1* illustrates the pattern of response rates to the SSA mailings through December 31, 1999. The y-axis indicates the number of screenings per day, and the x-axis depicts all weekdays during the mailing period, labeling every Monday with the appropriate calendar date. As this exhibit demonstrates, the number of screenings peaked between three and seven days following a mailing.

Also evident is the large volume of screenings performed following the two largest mailings on April 23, 1999, and May 14, 1999. As discussed in Chapter 4, the first mailing (March 17, 1999) contained outreach letters delivered to screening model areas only. Co-location model letters were sent beginning in the second mailing and application model letters in the third. The last batch of screening model letters was sent on June 7, 1999, while the last batch of co-location outreach letters was mailed on July 22, 1999. The last mailing, sent on August 9, 1999, contained only application model letters.

The graphs included in *Exhibit 5.2* portray screening volume. The graphs depict the average number of screenings as a percentage of letters sent to each site, for each day following a mailing, up to 30 days. As was obvious in the previous exhibit, screening activity spiked around four days post mailing. In addition, these graphs reveal the increased screening volume (relative to letters sent) for several of the application model sites. However, the screening is not likely to be a function of the demonstration model because letter recipients were not aware of which model was operating in their area. At most, the graphs reveal that the volume of screenings might be related to the geographic area and other factors that are not evident in these graphs. Thus, as Chapter 8 discusses, the results suggest the need to conduct a hazard analysis for capturing which factors affect the timing of the screening.

**Exhibit 5.1**  
**Frequency of Screenings across Time**



Source: The Lewin Group tabulations of screening data.

Note: Y-axis tick marks note Mondays; vertical, dashed lines indicate mailing dates; days with zero screenings correspond to observed holidays.

Exhibit 5.2

## Percentage of Screenings Conducted per Day post Mailing, by Model

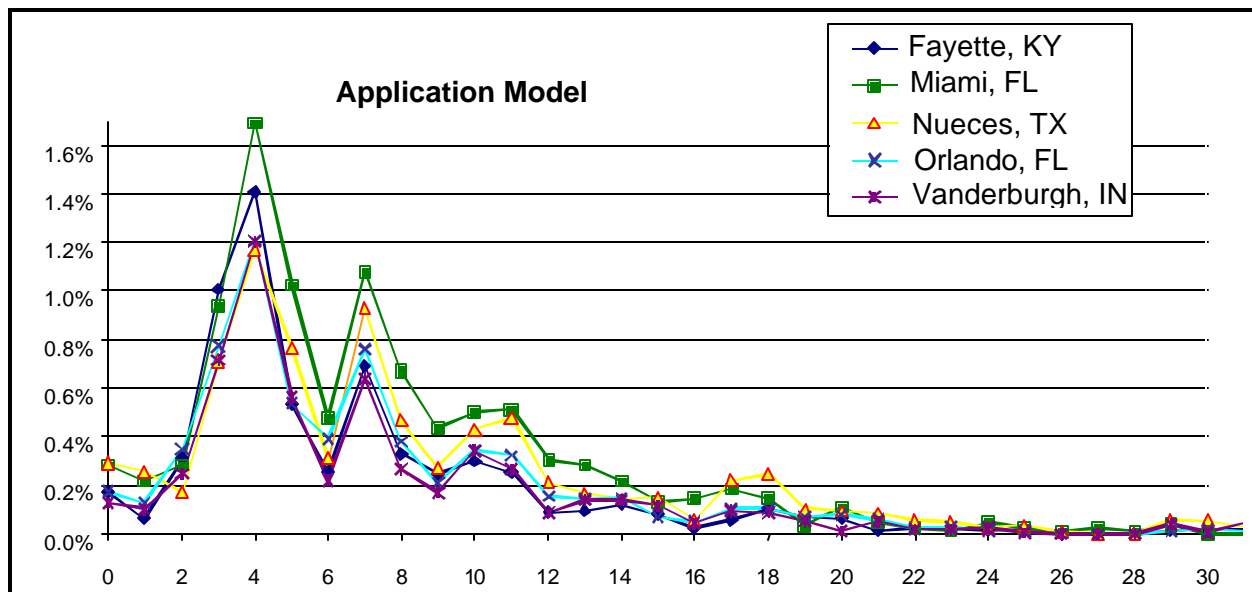
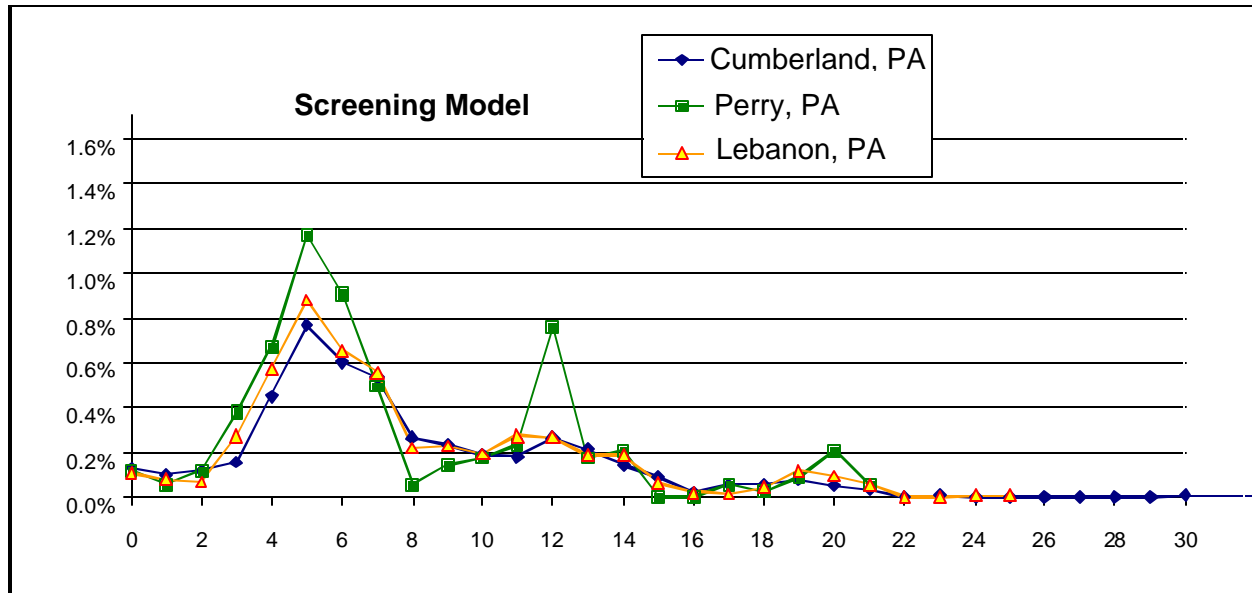
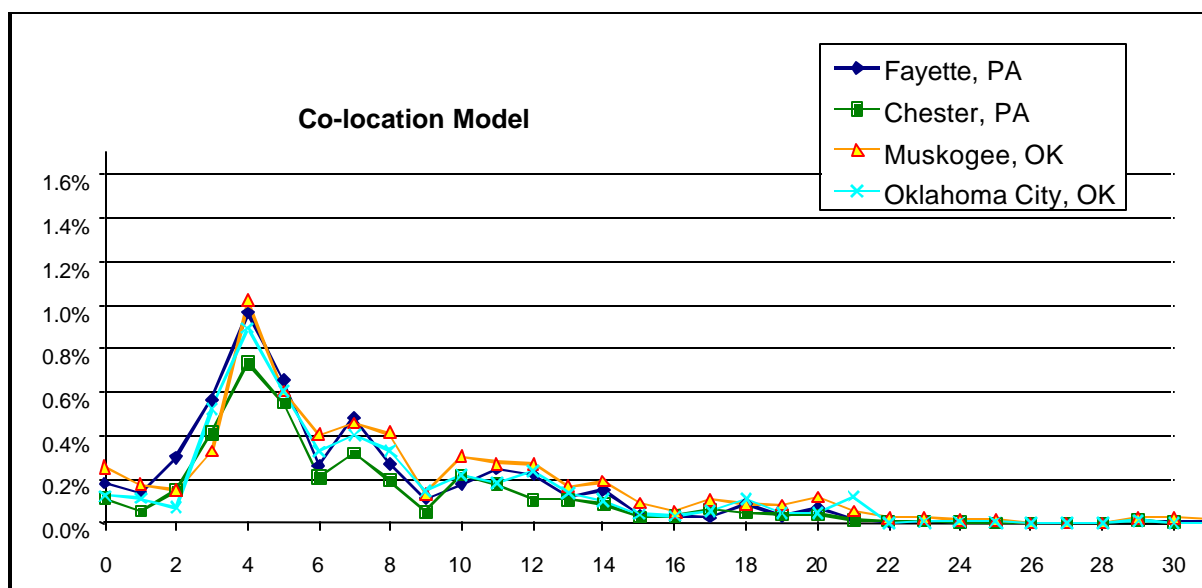


Exhibit 5.2—Continued



Source: The Lewin Group tabulations of screening data.

## B. Screening Time and Administrative Burden

SSA staff at the DSU and the field offices generally reported that the screening tool was easy to understand and simple to use. Across sites, screening staff spent an average of 8 minutes and 19 seconds screening each individual as measured by the length of time recorded by the PC program.<sup>29</sup> The median screening time across all sites was 7 minutes and 16 seconds (see *Exhibit 5.3*). These figures, which are notably higher than the averages and medians in most sites, are largely driven by the screenings performed at the DSU. The DSU screenings accounted for more than three-quarters of all screenings and were longer, on average. One possible explanation for this finding is that the timing of screenings at the DSU began immediately after the call was answered, whereas at many field offices there was some introductory dialogue with the individual before the opening of the screening software and the timing of the interview. For example, during the first few weeks of the demonstration, interviewers in Uniontown, Pennsylvania, felt that they were not capturing interview time accurately. As a result, they eventually started the screening tool as soon as the client sat down.

Across all sites, the average interview duration ranged from 4 minutes and 17 seconds in Evansville, Indiana, to 9 minutes and 20 seconds in Muskogee, Oklahoma. The lowest average might have been influenced by the interviewer's data collection method. For example, information in Lebanon, Pennsylvania, was collected on paper and then entered into the computer in a much more timely manner than would have been possible if the information had been input during the interview. A similar process could have taken place in sites with low average screening times. Nevertheless, interviews with Evansville staff indicate that the

<sup>29</sup> Screenings exceeding 60 minutes were assumed to be erroneous and were not considered in the calculation of average screening time. Around three percent of the records were omitted for this reason.

screening tool was started immediately (the site with the shortest average and median screening times).

### Exhibit 5.3

#### Average and Median Screening Times by Office

Field Office	Average Screening Time	Median Screening Time
Carlisle, PA	5 min. 8 sec.	4 min. 27 sec.
Lebanon, PA <sup>a</sup>	7 min. 49 sec.	6 min. 51 sec.
Uniontown, PA	6 min. 52 sec.	6 min. 20 sec.
West Chester, PA	6 min. 27 sec.	5 min. 59 sec.
Muskogee, OK	9 min. 20 sec.	6 min. 37 sec.
Oklahoma City, OK	6 min. 2 sec.	4 min. 47 sec.
Lexington, KY	7 min. 44 sec.	6 min. 50 sec.
Miami, FL	6 min. 10 sec.	5 min. 42 sec.
Corpus Christi, TX	6 min. 24 sec.	5 min. 27 sec.
Orlando, FL	5 min. 50 sec.	4 min. 37 sec.
Evansville, IN	4 min. 17 sec.	3 min. 24 sec.
DSU 1 <sup>st</sup> Floor	8 min. 31 sec.	7 min. 11 sec.
DSU 7 <sup>th</sup> Floor	9 min. 12 sec.	8 min. 37 sec.
Massachusetts	5 min. 31 sec.	4 min. 15 sec.
<b>All Offices</b>	<b>8 min. 19 sec.</b>	<b>7 min. 16 sec.</b>

Source: The Lewin Group tabulations of screening data.

<sup>a/</sup> Three minutes were added to all screenings conducted at the Lebanon, Pennsylvania field office because screenings were originally documented on paper and data was entered into the PC at the conclusion of the interview, causing the original interview length times to underestimate the true amount of time spent screening each individual. Staff estimated that this was the amount of time saved by first recording data on paper.

Screenings performed by staff on the seventh floor of the DSU were slightly longer on average than those conducted by staff on the first floor. Staff on the first floor were more experienced and “filled in” during peak hours; seventh floor staff were newer to their positions but took phone screenings full time. These staff members were assigned to other tasks when the frequency of calls was low.

Although Buy-in activity increased workloads in the field offices, it did not appear to seriously disrupt other work. In addition to the time spent actually interacting with beneficiaries, the screening process included administration time to download screening files from the PCs and email them to the central office. This activity would not be an issue if the screening practices were adopted on an ongoing basis because the data collected was specific to the demonstration. Also, the administrative burden of the downloads was eased when the systems staff were provided the ability to download the files centrally through the local area network (LAN), rather than each PC individually.

Most field offices found that the spikes in activity following the mailings created the largest challenge, and most had to pay at least some overtime during peak periods. Several staffers also

noted that the field offices would not want to assume this workload permanently without first being assured the necessary additional District Office Workload Report (DOWR) credits.<sup>30</sup>

### **C. Response to Outreach Letters**

As of December 31, 1999, a total of 16,028 people were screened by either the DSU or a local field office. Of those screened, 2.3 percent of records (372) were determined not to have a zip code contained within a demonstration site, according to their screening record. Thus, a total of 15,656 people had been screened within the scope of the demonstration.

*Exhibit 5.4.* outlines the number of individuals sent letters and screened. The first column notes the number of individuals sent an outreach letter. The next column indicates the number of individuals screened. The number of individuals screened who also received an outreach letter was calculated as well (Column D). Both figures were determined so that the percentage of individuals screened could be calculated two ways (Columns C and E).

Despite the high level of activity experienced by the DSU and the field offices in response to the mailings, the percentage of clients targeted with letters who were screened under the demonstration was between 6 percent (column E) and 6.3 percent (column C). Across the demonstration sites, the proportion of intended letter recipients who were screened varied, as indicated in the exhibit.

The percentage of individuals screened was greatest in Miami, Florida (10.5 percent) and Corpus Christi, Texas (9.0 percent). The remaining site with a high proportion of Hispanic residents, Orlando, Florida, screened 7.1 percent of the individuals who were sent letters. Thus, the three application model sites with the most significant number of Hispanics possessed the highest values for percent screened. The site that screened the lowest percentage of intended letter recipients is West Chester, Pennsylvania (4.0 percent).

The number and percent screened are also delineated by age group, sex, and Title II income later in the chapter (Section III).

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<sup>30</sup> SSA field office budgets are determined by how many District Office Workload Report (DOWR) credits they have. The number of DOWR credits reflect the productivity of the office and influence staffing allocations.



## Exhibit 5.4

Letter Recipients, Individuals Screened, and Potential Eligibles,  
by Site and Model

Site / Model	Number sent letter	TOTAL number screened	Percent screened (Total screened/ total sent letter)	Number screened AND sent letter	Percent screened (total screened & sent letter / total sent letter)
Column:	A	B	C = B/A	D	E = D/A
Carlisle, PA	15,413	794	5.2%	757	4.9%
Lebanon, PA	12,744	670	5.3%	640	5.0%
<b>Screening Model</b>	<b>28,157</b>	<b>1,464</b>	<b>5.2%</b>	<b>1,397</b>	<b>5.0%</b>
West Chester, PA	22,704	897	4.0%	854	3.8%
Uniontown, PA	11,293	610	5.4%	575	5.1%
Muskogee, OK	16,686	1,027	6.2%	946	5.7%
Oklahoma City, OK	35,184	1,790	5.1%	1,693	4.8%
<b>Co-Location Model</b>	<b>85,867</b>	<b>4,324</b>	<b>5.0%</b>	<b>4,068</b>	<b>4.7%</b>
Lexington, KY	15,761	1,063	6.7%	1,025	6.5%
Miami, FL	8,210	860	10.5%	829	10.1%
Corpus Christi, TX	18,607	1,674	9.0%	1,538	8.3%
Orlando, FL	66,585	4,728	7.1%	4,518	6.8%
Evansville, IN	15,817	983	6.2%	938	5.9%
<b>Application Model</b>	<b>124,980</b>	<b>9,308</b>	<b>7.4%</b>	<b>8,848</b>	<b>7.1%</b>
Massachusetts	N/A	560	N/A	N/A	N/A
<b>TOTAL including MA, if applicable</b>	239,004 <sup>a/</sup>	15,656	6.3%	14,313	6.0%

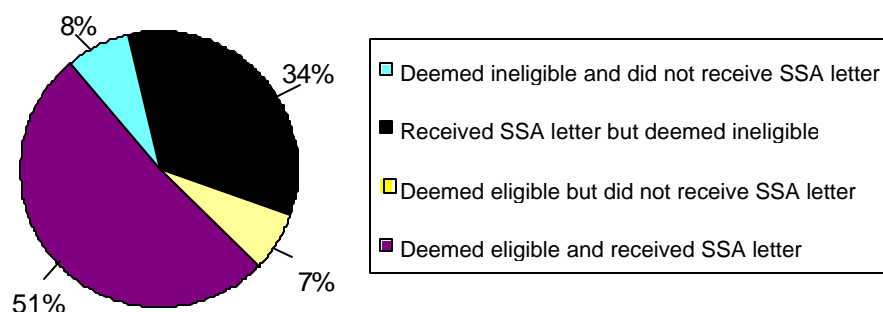
Source: The Lewin Group tabulations of Master Beneficiary Record data, screening data, and matched screening–MBR data.

<sup>a/</sup> The total number of letters sent is calculated at 239,004 as: 1) a number of people (44) received two letters (based upon beneficiary account number, last name, and date of birth); and 2) The total letters sent does not include 62 letters that were inadvertently sent to individuals living in one zip code in Uniontown, Pennsylvania that is not served by the Uniontown field office.

As evidenced in *Exhibit 5.5*, slightly more than half of the screened sample received an SSA letter and was determined to be potentially eligible (51 percent), while seven percent of the sample did not receive a letter but was considered potentially eligible. Thirty-four percent of the sample, however, received a letter but was determined to be ineligible and received a denial letter. The remaining eight percent did not receive an SSA letter and was deemed potentially ineligible.

### Exhibit 5.5

#### Eligibility and Outreach Letter Receipt



Source: The Lewin Group tabulations of matched screening and Master Beneficiary Record data.

#### D. Direct Service Unit versus Social Security Administration Field Office Screening

Screeners at the field offices usually faced the same challenges with the screening tool and with clients' attitudes as did the DSU screeners. However, because field office staff usually worked with clients face-to-face, clients were more willing to provide the necessary income and resource information.

In all three models that used targeted mailings, data from the screening software indicate that the majority of beneficiaries – about 78 percent – called the DSU to be screened (*Exhibit 5.6*).

### Exhibit 5.6

#### Frequency and Percentage of Screenings, by Site and Office

Welfare Office Location	Field Office Location (site)	Field Office		DSU		Total
		Screens	% of Total	Screens	% of Total	
Cumberland / Perry County, PA	Carlisle, PA	188	23.7%	606	76.3%	794
Lebanon County, PA <sup>a</sup>	Lebanon, PA	203	30.3%	467	69.7%	670
Fayette County, PA	Uniontown, PA	113	18.5%	497	81.5%	610
Chester County, PA	West Chester, PA	90	10.0%	807	90.0%	897
Muskogee, OK	Muskogee, OK	500	48.7%	527	51.3%	1,027
Oklahoma City, OK	Oklahoma City, OK	409	22.8%	1,381	77.2%	1,790
Fayette County, KY	Lexington, KY	171	16.1%	892	83.9%	1,063
Miami, FL	Miami Central, FL	192	22.3%	668	77.7%	860
Nueces County, TX	Corpus Christi, TX	626	37.4%	1,048	62.6%	1,674
Orlando, FL	Orlando, FL	550	11.6%	4,178	88.4%	4,728
Vanderburgh County, IN	Evansville, IN	246	25.0%	737	75.0%	983
<b>TOTAL</b>		<b>3,288</b>	<b>21.8%</b>	<b>11,808</b>	<b>78.2%</b>	<b>15,096<sup>a/</sup></b>

Source: The Lewin Group tabulations of screening data.

<sup>a/</sup> Total differs from total in *Exhibit 5.4* because it does not include 560 individuals from Massachusetts who were screened.

This is not surprising because a telephone call requires less effort than a trip to the field office. However, this figure varies substantially by site. For example, only 51 percent of screens in Muskogee, Oklahoma, were performed by the DSU (which, as discussed below, is likely explained by office screening practices), while 90 percent of screenings in West Chester, Pennsylvania and 88 percent in Orlando, Florida, were performed by the DSU (see also *Appendix F*). The DSU performed most screenings despite the fact that SSA representatives mentioned that many seniors prefer face-to-face contact at the office to using the telephone.

The percentage of screenings performed by the DSU or local field office remained consistent across time (*Exhibit 5.7*). However, there was a notable dip in late June, when the percentage of screenings by the DSU decreased from 81 percent during the weeks of June 12 to June 25 to 67 percent in the following period (which corresponded with the Fourth of July weekend), before returning to its previous level in the next two-week period. A similar pattern prevailed over Labor Day.

### Exhibit 5.7

#### Frequency and Percentage of Screenings, by Two-Week Period and Office

2 Week Period	Field Offices		DSU		Total
	Screens	% of Total	Screens	% of Total	
March 16 - April 2	97	23.8%	310	76.2%	407
April 3 - April 16	146	16.8%	725	83.2%	871
April 17 - April 30	363	19.8%	1,468	80.2%	1,831
May 1 - May 14	333	28.4%	838	71.6%	1,171
May 15 - May 28	555	22.9%	1,865	77.1%	2,420
May 29 - June 11	259	22.6%	885	77.4%	1,144
June 12 - June 25	240	18.6%	1,053	81.4%	1,293
June 26 - July 9	259	33.0%	527	67.0%	786
July 10 - July 23	204	18.3%	911	81.7%	1,115
July 24 - Aug 06	231	17.4%	1,096	82.6%	1,327
Aug 7 - Aug 20	231	16.7%	1,155	83.3%	1,386
Aug 21 - Sept 3	103	23.1%	342	76.9%	445
Sept 4 - Sept 17	76	33.9%	148	66.1%	224
Sept 18 - Oct 1	56	28.7%	139	71.3%	195
Oct 2 - Oct 15	28	23.0%	94	77.0%	122
Oct 16 - Oct 29	21	24.4%	65	75.6%	86
Oct 30 - Nov 12	27	32.5%	56	67.5%	83
Nov 13 - Nov 26	21	30.9%	47	69.1%	68
Nov 27 - Dec 10	27	38.6%	43	61.4%	70
Dec 11 - Dec 31	11	21.2%	41	78.8%	52
TOTAL	3,288	21.8%	11,808	78.2%	15,096 <sup>a/</sup>

Source: The Lewin Group tabulations of screening data.

<sup>a/</sup> This figure differs from the total in *Exhibit 5.4* because it excludes the 560 individuals from Massachusetts.

In several sites, individuals were screened more than once, often weeks apart. In Muskogee, Oklahoma, in particular, more than 60 individuals were screened multiple times. For example, when screenings per week were originally calculated for the June 12 to June 25 period on receipt of that data, 87 individuals were determined to have been screened by the DSU. However, as new screening data were received and the process of deleting older duplicates was used, it was

calculated that only 53 people had been screened during this same period.<sup>31</sup> The reason for this discrepancy is that 34 people were re-screened at a later date. The older June records for these individuals were disregarded so as not to double count them, and they appear in later screening periods as having been screened by the field office. This method of dealing with re-screenings in the data was used for all sites.

In Muskogee, Oklahoma, the additional screenings resulted from re-screening by the co-located worker who took applications. This worker re-screened individuals who had come to the office for an appointment either because the field office had not yet received the appointment letter containing the original screening information (e.g., income and resources) or because the letter received from SSA was not readily accessible, making it less burdensome to simply re-screen the individual.

### **E. Screening Issues Associated with the Widow(er)s Model**

In sharp contrast to the sites' using models that relied on outreach letter mailings, the widow(er)s model sites suffered from a different problem—little activity resulting from the demonstration. The low volume was the result of the relatively low incidence of clients' becoming widowed in any two-week period and the fact that many of these clients did not contact the field office. In many instances, after the death of a client's spouse, the field office was notified by the funeral director and benefits were stopped or adjusted. Thus, the widow(er)s had no need to contact the field office, unless they had questions. This demonstration model depended on field office staff to identify the appropriate clients who came in for other reasons. Because of low volume, the process never became routine, so staff might have forgotten to look out for eligible clients. In the Haverhill, Massachusetts field office, for example, the service representatives (SR) forgot to screen walk-ins because this was not made a priority and because he saw so few widow(er)s.

One screener mentioned that it was particularly difficult to get information about resources over the telephone. She was calling widow(er)s that she had identified herself from funeral director death report forms, before doing so was made an official part of the widow(er)s model. Because she was calling these clients rather than responding to calls made in response to outreach letters, clients might have been extra wary of giving out sensitive information over the telephone.

Also, one field office manager thought that the number of changes made over the course of the demonstration to the procedures the field office was instructed to follow added to the administrative burden of the demonstration. The additional work heightened the feeling that the demonstration created a large amount of work for little return.

## **III. CHARACTERISTICS AND POTENTIAL ELIGIBILITY OF THOSE SCREENED**

This section provides detailed information on the individuals who were screened. It begins with an overview of the screened sample's demographic characteristics, followed by a discussion of potential eligibility.

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<sup>31</sup> See Appendix F, Table 5 for Muskogee, Oklahoma's screenings per two-week period and office.

## A. Basic Demographics of Those Screened

The majority of those screened were female (69 percent) and nearly 30 percent of the individuals screened reported that they were married. In addition, a majority of the sites conducted less than one percent of their screenings in Spanish. In Miami, Florida; Orlando, Florida; and Corpus Christi, Texas, however, a significant portion of screening interviews were done in Spanish. Approximately 77 percent in Miami 17 percent in Orlando and 16 percent of screenings in Corpus Christi were conducted in Spanish.

Approximately 11 percent of the *screened* sample noted that they preferred to communicate in Spanish. However, a preference for English during the screening does not necessarily indicate ethnicity with certainty. It appears that many with a preference for Spanish correspondence, as indicated by their Master Beneficiary Record (MBR), participated in their screening in English. As noted in **Exhibit 5.8**, of those whose screenings were done in English, 1.7 percent had received a letter in Spanish. Conversely, of those who performed a screen in Spanish, 12.4 percent had received an SSA outreach letter in English.

### Exhibit 5.8

#### Language Preference in the MBR by Language Preference during Screening

SSA letter sent in →	Unknown	English	Spanish	TOTALS
Screen performed in ENGLISH	<b>9,220</b> 77.46 (row %)	<b>2,481</b> 20.84 (row %)	<b>202</b> 1.70 (row %)	<b>11,903</b> 100 (row %)
Screen performed in SPANISH	<b>440</b> 28.31(row %)	<b>192</b> 12.36 (row %)	<b>922</b> 59.33 (row %)	<b>1,554</b> 100 (row %)

Source: The Lewin Group tabulations of matched screening and Master Beneficiary Record data.

## B. Potential Eligibility by Site and Demographic Characteristics

This section explores potential eligibility as it relates to site, age, monthly Title II income, sex, marital status, and language preference. **Exhibit 5.9** delineates the number and percent eligible (of those sent SSA letters) by site and model. As previously noted, statistics are presented for the total screened and potentially eligible and also for those sent an outreach letter.

The table indicates that Miami and Corpus Christi (two application model sites) had the highest percentage of potentially eligible claimants, of those sent letters, at 6.5 percent and 5.6 percent, respectively (see Column D of **Exhibit 5.9**). Miami, the site with the highest rate of potential eligibility is also the site with the lowest primary insurance amount (PIA) among its intended SSA letter recipients indicating that past income might be negatively correlated with potential eligibility. The sites with the highest PIAs (the Pennsylvania sites) had the lowest potential eligibility rates.

Column F in **Exhibit 5.9** calculates the percent eligible of those who were screened. It closely mirrors the previous trend because Corpus Christi has the highest percentage at 70.9 followed by Miami at 66.4 percent. Pennsylvania sites occupy the four lowest spots on this percent eligible

scale. The percentage potentially eligible for the screening model is 44.3 percent compared to a demonstration average of 60.3 percent.

### Exhibit 5.9

#### Potential Eligibility of Individuals Sent Letter, by Site and Model

Site / Model	Number Screened and Sent Letter	Number Potentially Eligible	Number Sent Letter and Potentially Eligible	Percent Potentially Eligible (of those sent letter)	Percent Potentially Eligible (of screened & sent letter)	Percent Potentially Eligible (of those screened)
Column:	A	B	C	D = C/ total sent letter	E = C/A	F = B/ total screened
Carlisle, PA	757	346	341	2.2%	45.0%	43.6%
Lebanon, PA	640	303	276	2.2%	43.1%	45.2%
<b>Screening Model</b>	<b>1,397</b>	<b>649</b>	<b>617</b>	<b>2.2%</b>	<b>44.2%</b>	<b>44.3%</b>
West Chester, PA	854	519	467	2.1%	54.7%	57.9%
Uniontown, PA	575	358	314	2.8%	54.6%	58.7%
Muskogee, OK	946	639	560	3.4%	59.2%	62.2%
Oklahoma City, OK	1,693	1,162	1,050	3.0%	62.0%	64.9%
<b>Co-Location Model</b>	<b>4,068</b>	<b>2,678</b>	<b>2,391</b>	<b>2.8%</b>	<b>58.8%</b>	<b>61.9%</b>
Lexington, KY	1,025	690	647	4.1%	63.1%	64.9%
Miami, FL	829	571	537	6.5%	64.8%	66.4%
Corpus Christi, TX	1,538	1,187	1,050	5.6%	68.3%	70.9%
Orlando, FL	4,518	2,846	2,631	4.0%	58.2%	60.2%
Evansville, IN	938	608	556	3.5%	59.3%	61.9%
<b>Application Model</b>	<b>8,848</b>	<b>5,902</b>	<b>5,421</b>	<b>4.3%</b>	<b>61.3%</b>	<b>63.4%</b>
Massachusetts	N/A	217	N/A	N/A	N/A	38.8%
TOTAL including MA where applicable	14,313	9,229	8,429	3.5%	58.9%	60.3%

Source: The Lewin Group tabulations of Master Beneficiary Record data and matched screener-MBR data.

<sup>a/</sup> Indicates the total number potentially eligible because no outreach letters were sent.

### C. Potential Eligibility by Demographic Characteristics

*Exhibit 5.10* presents the percent of letters sent, the percent of individuals screened, and the percent determined potentially eligible by age group, sex, and Title II income as a percent of the poverty guideline.

Data indicate that younger individuals were more likely to respond to the SSA letter (that is, had a higher percent screened rate). Younger respondents were also more likely to be screened eligible. Of those over the age of 65, the oldest respondents (aged 85 and older) were also more likely to be screened potentially eligible. The likelihood of being screened and being screened potentially eligible does not appear to be related to sex because males and females had similar percent screened and percent potentially eligible rates.

**Exhibit 5.10****Screening and Potential Eligibility Rates by Age, Sex, and Title II Income**

Characteristics	Percentage of Letters Sent	Percent Screened (of those sent letters)	Percent Potentially Eligible (of those screened)
Total	100.0	5.6	59.9
<b>Age</b>			
<40	1.9	8.9	82.1
40–54	4.7	9.8	74.3
55–64	6.0	10.3	69.0
65–69	24.1	5.1	56.9
70–74	23.0	5.2	54.3
75–79	19.5	4.9	55.6
80–84	10.7	5.1	56.4
85+	10.1	4.4	60.9
<b>Sex</b>			
Male	36.5	5.7	59.1
Female	63.5	5.6	60.4
<b>Title II Income as a Percentage of the Poverty Guideline</b>			
<50	8.4	4.4	60.9
50–100	47.9	5.7	62.1
101–120	24.9	6.5	60.8
121–135	18.7	4.7	51.0

Source: The Lewin Group tabulations of Master Beneficiary Record data and matched screener–MBR data.

We would expect that the response rate and percent screened eligible might be higher among those with lower Title II income as a percentage of the poverty guideline. However, the data presented in *Exhibit 5.10* indicate that those with Title II income less than 50 percent of the poverty guideline were least likely to be screened and had about the same probability of being found potentially eligible as those in higher Social Security income groups. This indicates that low Title II income might not be a good predictor of potential eligibility for the Buy-in program. It might be that those with particularly low Title II income have other sources of income, possibly from a spouse that could not be identified by the MBR or from government pensions. Also, those at the higher end of the Title II income as a percentage of the poverty guideline had a lower probability of being screened eligible, which makes sense because even a little income in addition to Social Security would push these individuals above the allowable limits. In the Interim report, we will conduct a more thorough analysis of the characteristics of those responding to the letters and screened potentially eligible by Title II income distribution as a percentage of the poverty guideline. We will also look more closely at those screened out.

Potential eligibility also varied according to the language preference indicated on the MBR. The matched data sample allowed for the calculations in *Exhibit 5.11*, which reveal that those with an indicated preference for correspondence in Spanish had a much higher likelihood of being screened. Thirteen percent of those whose MBR record indicated a Spanish language preference were screened and 8.2 percent were deemed potentially eligible. Only 5.5 percent of those with a preference for English were screened with a potential eligibility rate of 3.3 percent. The rates of those whose language preference is unknown were similar to those whose MBR record noted a preference for English.

**Exhibit 5.11**  
**Screening and Eligibility Rates by Language Preference**

<b>Language Preference (MBR):</b>	<b>Unknown</b>	<b>English</b>	<b>Spanish</b>
Number Sent MBR Letter	181,415	49,045	8,650
Number Screened <sup>a</sup>	9,660	2,673	1,124
Percent Screened	5.3%	5.5%	13.0%
Number Potentially Eligible	5752	1,603	708
Percent Potentially Eligible <i>of those sent a letter</i>	3.2%	3.3%	8.2%
Percent Potentially Eligible of those screened	59.5%	60.0%	63.0%

Source: The Lewin group tabulations of Master Beneficiary Record data and matched screening–MBR data.

#### **D. Potential Eligibility by Income and Resources**

Potential eligibility was determined by calculations of a variety of resource and income sources, variables captured by the screening tool. Before fielding specific questions concerning resources and income, however, the screening staff looked up the Title II income from the MBR. Often this amount was large enough that the screening software determined the individual ineligible for the Buy-in program and automatically generated a denial letter. As a result, no data were collected on subsequent resource and income questions.

Individuals with allowable Title II income amounts were asked questions about the value of savings and checking accounts, stocks and bonds, certificates of deposit (CD), cash on hand, non-residential real estate investments, and whether any of these resources had been set aside for burial.<sup>32</sup> If total resources exceeded \$4,000 and \$6,000 for individuals and couples, respectively, the individual was determined ineligible and the screening was terminated. For eligible individuals or couples with resources totaling these specified amounts or less, the screening program continued to collect information concerning income. Individuals were asked about the receipt and amount of wages (gross monthly amount before deductions); self-employment (net monthly amount after deductions); Social Security (before deductions); Veterans' pension; federal, state, local, or private pension; alimony; and other income. All income and resource questions were asked about the claimant and the claimant's spouse (if applicable).

**Exhibits 5.12** and **5.13** outline potential eligibility by resource and income amounts. **Exhibit 5.12** delineates potential eligibility, while **Exhibit 5.13** provides a detailed account of screened individuals' resource and income levels. Both tables break down the statistics by marital status. The first column of both exhibits presents data for those who should have been screened eligible based on income and resources. The second column includes those who reported monthly Title II benefits below the income limits and who had resource amounts below the maximum allowable amount but who had total monthly income above the limits. The next column includes those whose resources exceed the limit but whose Title II benefits do not, while the last column indicates potential eligibility and monthly Title II benefits for screened applicants whose Title II benefits exceeded the limit.

<sup>32</sup> If the claimant answered that some of his or her resources had been set aside for burial, \$1,500 was subtracted from the individual's net resources.



Among those screened, around 60 percent were found to be potentially eligible, or, conversely, approximately 40 percent were found to be ineligible. As illustrated in **Exhibit 5.12**, married individuals were more likely to be screened ineligible, as compared with single individuals, largely because of monthly Title II income. Husbands and wives often have separate benefit records in the MBR and, thus, one or both might have received a letter alerting them of their potential eligibility. SSA administrative data do not readily link the records of members of married couples. Therefore, for most married couples, this letter was based upon the individual's income information and was negligent of the fact that the couples' *combined* Title II income often exceeded the limit for the Buy-in.

### Exhibit 5.12

#### Reasons for Being Screened Ineligible, by Marital Status

Marital Status	Total Screened Potentially Eligible	Monthly Title II Income Exceeds Limit	Resources and Assets Exceed Resource Limit	Total Monthly Income Exceeds Income Limit	Total Screened Potentially Ineligible
Single Claimants	69.6%	1.7%	16.8%	11.5%	30.4%
Married Claimants	41.2%	26.2%	12.8%	19.5%	58.8%
All Screenings	61.1%	9.0%	15.6%	13.9%	38.9%

Source: The Lewin Group tabulations of screening data.

Note: The individuals who had an invalid zip code, who were not receiving Medicare Part A, or who were receiving Medicare Part A premiums are not included in this table (or in the following table, **Exhibit 5.13**) because they were not asked about monthly Title II benefits, resources, or other income (448 records). In addition, those married units where the designated spouse is not receiving Medicare Part A are not included because these units report only the individual (rather than the couple's total) monthly Title II amount. Thus, they can be screened out at an early stage if their monthly Title II benefit is over the single-person limit. Fewer than 1 percent of screenings (0.8 percent) fell into this category.

The screened sample, as grouped by income and resources, averaged a potential eligibility rate of 60.3 percent (see Column G of **Exhibit 5.9**), including records not depicted in **Exhibits 5.12** and **5.13** because of 1) their being screened out at an early stage, i.e., for not receiving Medicare Part A or for receiving premium Part A for disabled working individuals<sup>33</sup> (116 records); 2) the spouse's ineligibility (121 records); and 3) outliers whose monthly Title II income was coded as being above possible limits (55 records). Without including these records, the eligibility rate would be 61.1 percent, as calculated in **Exhibit 5.12** above.

It is important to note that 14 individuals are categorized as potentially eligible based on income and resources although they, in fact, received a denial letter. These individuals would have been screened eligible if they had been screened *later* in the demonstration. That is, they were ineligible based on the earlier 1998 limits but fell below the 1999 limits used for the table. All 14 screenings were performed in March 1999, when the older limits were still used. In addition, two records received both an appointment and denial letter because of an early software glitch.

<sup>33</sup> Qualified Disabled and Working Individuals (QDWI) are people who were previously entitled to Medicare on the basis of disability and who retain Medicare Part A through payment of a premium. Medicaid covers this premium for QDWIs with limited income and resources.

They are grouped in the ineligible category in the following exhibit but were considered potentially eligible in the calculations in **Exhibit 5.9**.

According to **Exhibit 5.12**, approximately nine percent of those screened had Title II income above the Buy-in eligibility limits. However, a much larger proportion of married couples exceeded the limit than single claimants – 26.2 percent of couples compared with just 1.7 percent of single claimants.<sup>34</sup> Couples sent outreach letters were more likely to exceed the income criteria than single claimants because the MBR income data used to identify possible eligibles understated income for some couples. Specifically, if each spouse receives benefits based on his or her earnings rather than the higher earner's earnings, the MBR will contain separate records for each spouse. Therefore, even if the sum of the two income amounts exceeded the eligibility limits, both spouses would be identified as under the limits.

### Exhibit 5.13

#### Average Resources and Income by Potential Eligibility Determinations

SINGLE CLAIMANTS				
Income / Resource Category	Values for those under monthly Title II limit, less than or equal to resource limit, and less than or equal to income limit	Values for those under monthly Title II limit, below resource limit, and above total income limit	Values for those under monthly Title II limit but above resource limit	Values for those above monthly Title II limit
Sample Size	7,514	1,237	1,819	186 <sup>a</sup>
Monthly Title II	\$660.86	\$700.93	\$677.47	\$1,067.39
<b>Reported Resources</b>				
Checking	\$327.80	\$333.26	\$2,093.79	NA
Savings	\$273.51	\$312.78	\$8,109.58	NA
CDs	\$63.99	\$71.66	\$10,720.91	NA
Stocks / Bonds	\$15.06	\$18.70	\$4,121.05	NA
Cash	\$11.78	\$12.23	\$47.39	NA
Real Estate	\$8.72	\$5.59	\$4,748.54	NA
Total Resources <sup>b</sup>	\$700.87	\$754.21	\$29,841.26	NA
<b>Reported Income</b>				
Wages <sup>c</sup>	\$16.71	\$263.00	NA	NA
Self Employment	\$1.32	\$21.57	NA	NA
Social Security <sup>d</sup>	\$631.14	\$751.61	NA	NA
VA Pension	\$8.53	\$62.28	NA	NA
Other Pension	\$23.64	\$321.19	NA	NA
Alimony	\$0.97	\$12.82	NA	NA
Other Income	\$8.14	\$291.20	NA	NA
Total Income	\$690.45	\$1,723.67	NA	NA

<sup>34</sup> The Title II annual income limit for single claimants is \$947, while the limit for couples is \$1,265.

**Exhibit 5.13 -continued**

<b>MARRIED CLAIMANTS</b>				
<b>Income / Resource Category</b>	<b>Values for those under monthly Title II limit, less than or equal to resource limit, and less than or equal to income limit</b>	<b>Values for those under monthly Title II limit, below resource limit, and above total income limit</b>	<b>Values for those under monthly Title II limit but above resource limit</b>	<b>Values for those above monthly Title II limit</b>
Sample Size	1,904	903	593	1,209 <sup>a</sup>
Combined Monthly Title II	\$838.94	\$865.83	\$888.21	\$1,491.98
<b>Combined Reported Resources</b>				
Checking	\$419.42	\$428.10	\$2,853.27	NA
Savings	\$428.23	\$540.67	\$10,075.78	NA
CDs	\$88.51	\$124.14	\$14,360.18	NA
Stocks / Bonds	\$21.12	\$34.39	\$5,116.17	NA
Cash	\$15.55	\$19.69	\$42.33	NA
Real Estate	\$32.19	\$30.75	\$8,871.46	NA
Total Resources <sup>b</sup>	\$1,005.02	\$1,177.76	\$41,319.19	NA
<b>Combined Reported Income</b>				
Wages <sup>c</sup>	\$141.88	\$1,015.09	NA	NA
Self Employment	\$9.12	\$28.03	NA	NA
Social Security	\$838.07	\$944.66	NA	NA
VA Pension	\$14.39	\$89.65	NA	NA
Other Pension	\$23.99	\$344.46	NA	NA
Alimony	\$0.00	\$0.88	NA	NA
Other Income	\$12.41	\$389.29	NA	NA
Total Income <sup>d</sup>	\$1,039.86	\$2,812.06	NA	NA

Source: The Lewin Group tabulations of screening data.

<sup>a/</sup> This number indicates the sample size after the deletion of 12 records with monthly Title II benefit amounts above the maximum, by 1998 standards.

<sup>b/</sup> This amount does not include the \$1,500 reduction if resources are intended for burial.

<sup>c/</sup> Average wages and self-employment are calculated before the disregard of \$65 and 50 percent .

<sup>d/</sup> This variable is the beneficiary's monthly Title II benefit amount. Its value should equal the value of "monthly Title II benefit" because interviewers were instructed to enter both values based on the individual's MBR record; however, the "Social Security" value might have been self reported at times because it is included with several other self-reported resource and income questions.

Approximately 15.6 percent of screened individuals were found ineligible because of resources (16.8 percent of single claimants and 12.8 percent of married claimants). As evidenced in **Exhibit 5.13**, those individuals and couples with resources above the \$4,000 and \$6,000 limits had substantial resources: Single claimants average nearly \$30,000 in total resources although married claimants averaged more than \$40,000, much of it from CDs and savings accounts.

Another 13.9 percent exceeded the income limits when total income was taken into account (11.5 percent of single and 19.5 percent of married individuals). Single and married individuals in this group had average resources of \$754.21 and \$1,177.76 and average monthly income of \$1,723.67 and \$2812.06, respectively.

#### **IV. DEPARTURES FROM THE ORIGINAL DEMONSTRATION APPROACH**

During site visits and phone interviews, it became apparent that staff were not always implementing screening-related activities as planned. A variety of departures from the intended screening process in several of the sites included the following:

- Despite the fact that the training package instructed field office staff to read the Privacy and Paperwork Reduction Act Notice to individuals before screening, many field office screeners neglected to do so.
- At the Muskogee, Oklahoma field office, the co-located state worker did almost all the screening of walk-ins. This function was originally conceived as a job for a field office worker.
- Early in the demonstration, the Brookline, Massachusetts field office (widow[er]s model) began going through funeral director death report forms (SSA-721s) to identify widow(er)s with the appropriate income level and Medicare status. This was considered at most a mildly effective form of outreach because field offices often go through their stacks of SSA-721s, which are kept for three months, when they have free time to make sure the widow(er)s status has been appropriately modified. As explained earlier, this was eventually adopted as standard policy across all widow(er)s sites.
- The Haverhill, Massachusetts field office staff reported that their office set-up has resulted in no walk-in screenings' being done. The receptionist also worked as an SR performing many front-end tasks. This SR is often under pressure to work quickly because people are waiting in line in the same room. It was intended the SR would screen individuals who might qualify for the Buy-in program (based on Title II income and receipt of Medicare Part A). However, because of a backlog in the waiting room, screening was conducted only with individuals who requested Buy-in benefits explicitly. In addition, because widow(er)s Buy-in screenings occur so infrequently, the SR was likely to forget to look for appropriate clients even if the waiting room were not full.
- The Haverhill field office staff also reported that although they began going through SSA-721 forms after the policy change to identify possible Buy-in candidates, they were not using the screening tool on these clients, so the identified individuals would not show up in all of the evaluation data.

#### **V. STAFF SUGGESTIONS FOR IMPROVEMENT**

Departures from the intended model indicate a number of ways that field offices aimed to improve the screening process. In addition, staff in field offices, as well as in the state agencies, offered suggestions for improving the screening process and screening tool.

Field office staff reported the following difficulties:

- The screening tool did not allow the user to back up to a previous screen in the event that, for example, the client remembered additional income or resources after the relevant screen had passed. This was a universal complaint among all screening staff in all locations.
- Printing the appointment letter from the screening tool was time consuming, often to the extent that the screener was not ready when the next call arrived.
- Most DSU screeners were reading the Privacy and Paperwork Reduction Act Notice verbatim, as instructed, and those who did not read it verbatim closely paraphrased it. However, they reported that the statement intimidated many clients.
- Some clients were uncomfortable or unwilling to give information about resources over the phone. The same was true, to a lesser extent, for income.
- Most screening staff interviewed appeared well informed, but there were exceptions. One did not know that Buy-in benefits might include coverage for co-payments and deductibles. Several were misinformed about how to schedule appointments at different sites.

State Medicaid agency staff had a number of suggestions for improvements including the following:

- The screening tool would benefit from specific fields for interest income, source of interest income, and government pensions.
- Ideally, the screening tool should be fully integrated with MBR data. Also, linking it to databases for other government programs for verification would speed applications.
- The screening tool should screen more accurately for the spouse's income because this often put the client over the limit, making him or her ineligible.
- One state thought it might be helpful to know whether an individual was screened by the DSU or the field office. Staff in this state agency felt that DSU staff were not as informed about the program as local field office staff were.
- Some SSA field offices sent the income and resources attachment in letters only for individuals who were potentially eligible. State staff indicated that it would be helpful to have this same information for potential ineligibles also because they are provided contact information for the state in case they want to verify ineligibility. Having this information at the state would assist them in discussing why they are ineligible with those who do inquire. Field offices were supposed to forward potential ineligible letters to state Medicaid agencies, but not all did so.

If the efforts of the demonstration were implemented more broadly, a complete review of the PC-based screening tool for both functionality and content would have to be conducted. Such a review might address the issues raised by both field office and state Medicaid agency staff.

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## **CHAPTER 6: APPLICATION PROCESS**

Although all models except the widow(er)s model used the same basic approach for outreach and screening, the models used different paths to get the beneficiary from screening to the completion of a Buy-in application. This chapter describes all of the activities of the SSA field offices, state Medicaid agencies, and the Direct Service Unit (DSU) after clients were screened. This includes referral to an application appointment, the process of submitting an application, application adjudication, recertification, and the coordination across offices required to carry out these steps.

The chapter is divided into eight sections that follow the flow of the application process. Section I describes the requirements that each state had for the submission of Buy-in applications during the demonstration, providing important information about the context in which the demonstration was carried out at each site. Section II describes how clients were directed from the initial screen to the actual application process under each model by site, and discusses any problems encountered or deviations from the planned approach that occurred at each site. Section III identifies potential barriers to clients' completing their Buy-in applications under each model by site. Section IV focuses specifically on the challenges the application model sites encountered when taking applications. Section V describes workload impacts of the application referral and submission process on the SSA field offices. Section VI describes the workload impacts on the state Medicaid agencies. Section VII discusses the potential for problems after initial Buy-in enrollment resulting from states' re-certification requirements. Finally, Section VIII provides suggestions offered by SSA field office staff and state Medicaid agency staff to improve the application referral and submission process.

### **I. REQUIRED PROCESS FOR SUBMITTING AN APPLICATION**

The requirements for Buy-in applications vary by state. We have identified three key aspects of states' application processes that might affect the viability of certain enrollment models: 1) the type of application form required; 2) the level of verification required for adjudication, and 3) the method of interview or application submission allowed. Some states modified their practices for the demonstration sites or made statewide changes before or during the demonstration period. *Exhibit 6.1* summarizes the policy each state employed during the demonstration.

## Exhibit 6.1

## State Application Process Characteristics Followed during the Demonstration

	Florida	Indiana	Kentucky	Massachusetts	Oklahoma	Pennsylvania	Texas
Demonstration Sites: S=Screening, C=Co-location, A=Application, W=Widow(er)s	Miami-A Orlando-A	Evansville-A	Lexington-A	Entire state-W	Muskogee-C Oklahoma City-C	Carlisle-S Lebanon-S Uniontown-C West Chester-C	Corpus Christi-A
<b>Application Form</b>							
Shorter Buy-in app. Statewide Demonstration sites Other sites	X	9/99 4/99 2 co. 4/99	X	4/99		7/99 5/99	6/98
Short app. for premium only				X		X	
Application includes benefits other than Buy-in	Community Medicaid; Outside of demo, also food stamps and others	Food stamps and Medicaid	No	Prescription benefits if client fills out one page supplemental form	Community Medicaid, food stamps, and others	Long form only	No
<b>Evidence/Verification Requirements</b>							
Self-declaration accepted	In demo only for initial application because of heavy workload; will require evidence for recertification	No	No	During demo QI and SLMB	No	No	X Conducting QC



**Exhibit 6.1—Continued**

	Florida	Indiana	Kentucky	Massachusetts	Oklahoma	Pennsylvania	Texas
<b>Application Submission</b>							
Method of intake used	In person or by telephone. Most done by phone (about 60%) Proxy by phone okay. Home visits are done, but rare.	In person for walk-ins. Over phone for call-ins.	Generally in person. By telephone if unable to travel to office.	By mail	Generally in-person. By telephone to alleviate scheduling problems	In person or by telephone	In person or by telephone. About half of applications are taken by phone.
Substantially different from state agency's approach?	No	No	No	No	Possibly more telephone applications under demo	Possibly more telephone applications under demo	Possibly more telephone applications under demo

Source: The Lewin Group interviews with state Medicaid liaisons.

- **Application form.** Before the demonstration, Kentucky and Texas were the only participating states using a shortened application for Buy-in (see *Exhibit 3.1* in the discussion of state processes before the demonstration in Chapter 3). The other states required Buy-in applicants to fill out the same comprehensive application used for many other state benefits or for full Medicaid benefits before the demonstration. In contrast, all states except Oklahoma used a short form for at least a portion of the demonstration period.
  - Florida, Indiana, Kentucky, and Texas had short-form Buy-in applications in place at the start of the demonstration. All four states used the application model where the SSA field office was responsible for taking applications. The simplified applications streamlined the application-taking process for these field offices. In addition to these states, Massachusetts had a short form for premium-only benefits (i.e., Qualified Individual 1[QI-1] and Specified Low-Income Beneficiary[SLMB], but not Qualified Medicare Beneficiary [QMB]).
  - Pennsylvania (which contained both screening model sites and co-location model sites) adopted a short form for premium-only benefits (SLMB and QI-1) for the demonstration sites in May 1999, after the mailings had begun. The form went statewide in July.
- **Evidence and verification required.** Three states—Texas, Massachusetts, and Florida—accepted client “declaration” of income and resource amounts to some degree during the demonstration. This means that clients’ statements about their income and resources could be accepted without complete verification, making adjudication much easier. Texas was already using this practice statewide before the demonstration. Massachusetts accepted declaration under the demonstration for QI-1 and SLMB applicants but not for QMB applicants. Florida adopted a policy of accepting client declaration for initial applications under the demonstration in response to the large volume of applications but will require supporting evidence at each client’s annual recertification. (See the section on recertification at the end of this chapter for a discussion of the implications of recertification on the success of Buy-in outreach.)
- **Method of intake.** The use of in-person, by mail, or by phone guidelines for taking applications before the demonstration were followed during the demonstration. All demonstration states except Massachusetts required clients to have supervision and assistance with their applications, either in person or by telephone, or by proxy if necessary. Of these, Kentucky, Pennsylvania, and Oklahoma reported preferring that clients apply in person, but Florida, Pennsylvania, and Oklahoma appeared to allow a larger number of telephone applications to be taken during the application than was typical before the demonstration. Texas also appeared to take a large proportion of applications by telephone (about half). In contrast to the other states, Massachusetts normally preferred to mail applications to clients (either the short QI-1/SLMB form or the long form for QMB) and continued this practice under the demonstration.

These state requirements can have implications for the workability of certain Buy-in outreach models. Section II. C explores these in the discussion of potential barriers to application completion.

## II. SCHEDULING OF APPLICATION APPOINTMENTS

The different models required different kinds of coordination among the field office, state Medicaid agency, and Direct Service Unit (DSU) to ensure that clients who screened potentially eligible completed an official Buy-in application. Such coordination brought with it the possibility for communication problems between offices. *Exhibit 6.2* identifies the problems encountered in scheduling application appointments for clients by model and site. The table separates application appointment scheduling problems related to the DSU from those related to walk-ins to the SSA field office. The table also identifies deviations from the planned approach, innovations, and other challenges encountered by the SSA field offices as they tried to schedule application appointments. Because Massachusetts, the only state conducting the widow(er)s model, did not schedule application appointments, *Exhibit 6.2* does not include the widow(er)s model. That model is included, nevertheless, in the discussion below.

### A. Screening Model Sites

As explained in Chapter 3, when clients from areas using the screening model called the DSU, the DSU was to try to make an appointment with the state Medicaid agency. If impossible, the DSU was to give the client the state Medicaid agency's telephone number. Clients walking into the SSA field office were screened there, after which the field office screening staff were to attempt to make an application appointment with the state Medicaid agency.

The two screening model sites encountered the following challenges:

- The DSU mistakenly scheduled application appointments on the P/E calendars<sup>35</sup> of both screening model field offices, apparently confusing these with the co-location model, which were also in Pennsylvania. These screening model field offices had to call the clients back and refer them to the state Medicaid agency. This problem was, at least in part, a byproduct of the use of multiple models under a single demonstration project. A national SSA Buy-in outreach effort using a single approach among all field offices would avoid this source of confusion.
- At the outset of the demonstration, both screening model field offices failed to send denial letters to the state Medicaid agency as called for under the demonstration design. The issue came to light during an evaluation team site visit on May 13 and 14, 1999, and the field offices began forwarding the denial letters from that point forward.

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<sup>35</sup> The P/E calendar refers to the electronic "post-entitlement" scheduling calendar used by SSA, which allows authorized SSA employees to schedule appointments at field offices from any SSA location. The P/E calendar was used for Buy-in applicants because they were already entitled to SSA benefits before inquiring about Buy-in benefits.

**Exhibit 6.2**  
**Application Appointment Scheduling**

Sites by Model	Process for Scheduling Application Appointments for Clients Screened by Field Office	Time Slots Available for Application Appointment	Problems Related to DSU Appointment Scheduling	Information Captured in Application Log	Deviations / Problems / Innovations
<b>Screening Model</b>					
Carlisle, PA (Cumberland County)	One contact and one backup were assigned to take appointments at the Medicaid agency in Cumberland.	4/day; 45–60 minutes each  Two half-time trainees split these four.	The DSU, instead of state agency, occasionally scheduled appointments on the Field office P/E calendar, confusing screening and co-location models.	<ul style="list-style-type: none"> <li>• All referrals</li> <li>• No shows and cancellations</li> <li>• Approvals</li> <li>• Withdrawals</li> <li>• Reason for denial</li> </ul>	<p>Field office had trouble making application appointments at the state agency when the primary contact was not available in Cumberland. Also, Cumberland initially was not aware that the DSU would be calling for appointments.</p> <p>Field Office initially was not sending denial letters to the state.</p>
Carlisle, PA (Perry County)	Receptionist scheduled appointments in Perry County. When receptionist was not available, everyone else served as back up.	3/day  1 income maintenance worker			Some appointments were scheduled without notifying Perry County.
Lebanon, PA (Lebanon County)	Everyone at the Medicaid agency was able to schedule appointments. Two receptionists made appointments and mailed applications to potential eligibles. state agency more often called beneficiaries to schedule appointment than had one from the Field Office or DSU.	At peak, 6/day; started with 2–3/day  7 intake workers rotated with half doing Buy-in each day	The DSU, instead of state agency, occasionally scheduled appointments on the Field office P/E calendar, confusing screening and co-location models.	<ul style="list-style-type: none"> <li>• All referrals</li> <li>• No shows and cancellations</li> <li>• Approvals</li> <li>• Withdrawals</li> <li>• Reason for denial</li> </ul>	Field office initially was not sending denial letters to state.

Exhibit 6.2— Continued

Sites by Model	Process for Scheduling Application Appointments for Clients Screened by Field Office	Time Slots Available for Application Appointment	Problems Related to DSU Appointment Scheduling	Information Captured in Application Log	Deviations, Problems, and Innovations
<b>Co-location Model</b>					
Muskogee, OK (Muskogee, Cherokee, Adair, Wagoner and McIntosh County)	Co-located worker screened and took applications in one interview.	12/day, 6 by appointment, 6 by walk-in	Co-located worker found that the DSU summary letter sometimes had missing information, e.g. ,resources from CDs.	co-located worker log; monthly number of applications and approvals; no individual-level information.	
Oklahoma City, OK (Oklahoma County)	Walk-ins saw the co-located worker if there was an open time; otherwise an appointment was scheduled on the Field Office P/E calendar.	12/day	A limited number of time slots in the P/E calendar was a problem.	co-located worker log: <ul style="list-style-type: none"> <li>• Name</li> <li>• SSN</li> <li>• Application taken</li> <li>• Office for processing</li> </ul>	
Uniontown, PA (Fayette County)	Walk-ins scheduled an appointment for a future time on the field office's P/E calendar.	3/day, 5 days/week, 9:00 A.M.–1:00 P.M.	DSU occasionally scheduled application appointments in the wrong time slots.	<ul style="list-style-type: none"> <li>• Name</li> <li>• Case #</li> <li>• Application request #</li> <li>• Worker</li> <li>• Date/time of appt.</li> <li>• SSN</li> <li>• DOB</li> <li>• HIB</li> <li>• Application date</li> <li>• Status</li> <li>• Reason for denial</li> </ul>	Because of union requirements, used 17 rotating workers on a daily basis. Lack of a point-person that resulted might be related to the field office's failure to send eligible letters to the state Medicaid agency.  Ineligible letters also not sent.
West Chester, PA (Chester County)	Walk-ins scheduled an appointment for a future time on the field office's P/E calendar.	6/day, 53days/week, 9:00 A.M.–12:00 P.M.  more appointments in afternoon if volume was high	DSU occasionally scheduled appts. when not available, in wrong time slots; scheduled home visits or phone interviews even though not available; and would not print referrals in case of a reschedule or cancellation.	<ul style="list-style-type: none"> <li>• Name</li> <li>• SSN</li> <li>• Cancellation/No-show</li> <li>• Status</li> <li>• Reason for denial</li> </ul>	Field office found out late about the switch to staggered mailings, after having re-arranged schedules around the expected rush.

**Exhibit 6.2—Continued**

Sites by Model	Process for Scheduling Application Appointments for Clients Screened	Time Slots Available for Application Appointment	Problems Related to DSU Appointment Scheduling	Information Captured in Application Log	Deviations, Problems, and Innovations
<b>Application Model</b>					
Miami, FL (Dade County)	Walk-ins scheduled an appointment for a future time, usually on same day, on the field office's P/E calendar	5 days/week, 8:00 A.M.–3:30 P.M.	No problems with DSU.	<ul style="list-style-type: none"> <li>• Name</li> <li>• SSN</li> <li>• Number of Requests for Assistance</li> <li>• Approvals</li> <li>• Denials</li> <li>• Zip code</li> <li>• Service center</li> <li>• Date of received</li> <li>• Date of approval</li> </ul>	<p>Different terminology used by SSA and states –QI-1 versus Part B Medicare only (PBMO) caused confusion</p> <p>Followed up on those screened ineligible</p>
Orlando, FL (Orange and Osceola County)	Walk-in applications were taken immediately following their screen by different field office staff. Callers were advised to call the field office toll-free number to set up appointment on the field office P/E calendar.	<p>Approximately 10 appointments/hour, 30/day</p> <p>Someone always available to do walk-ins</p> <p>Separate tray for homebound</p>	At beginning of demonstration, DSU was giving the field office leads instead of appointments, requiring the field office to call the clients. field office reported that problem was eventually corrected.	<p>Service centers kept weekly logs:</p> <ul style="list-style-type: none"> <li>• Number received</li> <li>• Pending</li> <li>• Approvals</li> <li>• Denials</li> </ul> <p>Central office has 2 reports; 1 by week and 1 cumulative</p>	No scheduling issues
Evansville, IN (Vanderburgh County)	Same Title XVI CR screened and took application for walk-ins. Applications were taken immediately after the client was screened. Specific slots were reserved for walk-ins.	<p>9:00 A.M.–4:00 P.M., no specific slots</p> <p>Field office had specified walk-in days for applications in addition to those taken by appointment.</p>	field office manager reported that many people who called the Spanish line at the Direct Service Unit complained that they could not get an application appointment.	<p>Timesheet data collected:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• SSN</li> <li>• DOB</li> <li>• Zip code</li> <li>• Date of application</li> <li>• Date of authorization</li> <li>• Approvals and program</li> <li>• Reason for denial</li> </ul>	No scheduling issues

**Exhibit 6.2—Continued**

<b>Sites by Model</b>	<b>Process for Scheduling Application Appointments for Clients Screened</b>	<b>Time Slots Available for Application Appointment</b>	<b>Problems Related to DSU Appointment Scheduling</b>	<b>Information Captured in Application Log</b>	<b>Deviations, Problems, and Innovations</b>
Lexington, KY (Fayette County)	Applications were taken on same day as screening when possible (typically, a 20-minute wait). During peak periods, however, appointments usually needed to be scheduled for a future date. Three time slots per day were scheduled on the P/E calendar.	10:00 A.M., 2:00 P.M., 3:00 P.M., usually of 30 minutes duration	No problems with DSU	<ul style="list-style-type: none"> <li>• Name</li> <li>• SSN</li> <li>• Date of application</li> <li>• Approvals and program</li> </ul>	After the application was taken, the client was given a fact sheet, developed by the state, containing key state phone numbers.
Corpus Christi, TX (Nueces County)	Walk-in clients could either wait or schedule a future appointment on the Field Office P/E calendar.	12 slots/day, 6/CR, plus walk-ins	DSU occasionally scheduled application appointments on wrong calendar, resulting in double bookings. This occurred throughout the demonstration even though the field office manager alerted DSU of the problem several times.	daily log: <ul style="list-style-type: none"> <li>• SSN</li> <li>• Date of application</li> <li>• Worker assigned</li> <li>• Approvals and program</li> <li>• Denials</li> <li>• Reason for denial</li> <li>• Date of action</li> </ul>	At least a dozen clients had their applications taken twice. Field Office was unsure how these redundant application appointments were scheduled. They occurred largely in July during a period of high activity. No ineligible letters were sent. Initially, because of lack of communication between field office and state, field office was not including enough information on applications, resulting in more work for state Medicaid agency. This was corrected halfway through demonstration..

Source: The Lewin Group interviews with field office and state Medicaid Agency staff.

- The Carlisle, Pennsylvania field office had some difficulty scheduling appointments with the state Medicaid agency when the primary contact was unavailable. This highlights the importance of having trained backup staff available to take appointments. In contrast, the state Medicaid agency in Lebanon, Pennsylvania, trained everyone who answered the telephone to schedule an appointment, and the field office reported no problems scheduling application appointments with the state Medicaid agency.
- Because of an apparent lack of communication, the Cumberland County state Medicaid agency (i.e., one of the two Medicaid agencies working with the Carlisle, Pennsylvania field office) was unaware that the DSU would also be calling for appointments. This was resolved within the first few weeks.

## **B. Co-location Model Sites**

Clients from co-location sites who called the DSU were scheduled for application appointments on the appropriate field office's P/E calendar. Walk-in clients were sometimes seen for application appointments immediately following the screening and sometimes scheduled for a later time. The approach differed by demonstration site.

- The Oklahoma City, Oklahoma field office took applications for walk-ins the same day as their screening, if there was an open time. Otherwise, an appointment was scheduled for a future date on the field office's P/E calendar.
- At the Uniontown and West Chester, Pennsylvania field offices, walk-in clients scheduled an appointment for a future time on the field office's P/E calendar.
- At the Muskogee, Oklahoma field office, the co-located worker generally screened and took applications for walk-ins in one interview. Muskogee was unusual among co-location sites because the co-located worker was primarily responsible for all activities related to the Buy-in demonstration. Service representatives in the field office were available to assist in conducting screenings as needed during peak periods.

Many of the problems encountered in the co-location sites involved application scheduling by the DSU:

- The West Chester, Pennsylvania field office reported early problems with DSU-scheduled application appointments because West Chester chose to use time slot categories on the common scheduling system that differed from other field offices' categories. The Uniontown, Pennsylvania field office reported application scheduling mistakes made by the DSU, even though it used the same time slot categories as most other demonstration sites. Unlike the scheduling confusion experienced by the screening model sites mentioned above, this confusion was unrelated to the existence of multiple models and, therefore, would not necessarily be avoided by using one model uniformly across the country. Rather, it might have been, in part, because of differences in the ways that certain field offices used SSA's standard scheduling system. Avoiding this type of confusion in a nationwide program might require improved training at the DSU or more uniformity in scheduling procedures across field offices.



- The DSU reported that the number of application appointments available in the Oklahoma City, Oklahoma field office calendar was limited, sometimes preventing the DSU from scheduling appointments for clients they had just screened. This was a limitation of the P/E calendar that the DSU used to schedule application appointments at all co-location and application model sites. Field offices typically resorted to manually scheduling appointments themselves, outside the P/E calendar, to accommodate the overflow.
- The co-located worker in the Muskogee, Oklahoma field office found that the DSU summary letter lacked necessary resource information.

Other problems related specifically to the demonstration itself or to coordination between the co-located worker at the field office and the state Medicaid agency:

- The field office manager in West Chester, Pennsylvania, found out late about the switch to staggered mailings, after having already rearranged schedules around the expected mailing.
- Like the screening sites, the co-location model field offices also failed to regularly send denial letters to the state Medicaid agency. It was not always clear to the field offices—not even to co-located workers in the field offices—that the state Medicaid agency would find the denial letters useful. Some state Medicaid agencies agreed and did not want the denial letters, although others felt that having them in beneficiaries’ files was helpful for future reference in serving those beneficiaries.
- The Uniontown, Pennsylvania field office staff also failed to regularly send *eligibility* letters to the state Medicaid office and instead provided the letter to the screened client with instructions to take the letter to his or her appointment. It appears that Uniontown screening staff were doing this because this field office used 17 co-located workers on a rotating basis so there was no single Medicaid point of contact in the field office who could collect the letters and periodically bring them to the state Medicaid office.

### **C. Application Model Sites**

Clients in application model sites who called the DSU were scheduled for application appointments on the appropriate field office’s P/E calendar. Walk-in clients were sometimes seen for application appointments immediately following the screening and sometimes scheduled for a later time, depending on the volume of Buy-in inquiries at the field office.

- At the Evansville, Indiana field office, the same staff member who screened the client took the application immediately following the screening.
- At the other application model sites, clients typically were scheduled for application appointments on the same day as their screening if a time slot were available. During peak times, appointments had to be made for future dates.

As in the other sites, some application sites reported some problems involving appointments attempted through the DSU:

- The Orlando, Florida and Corpus Christi, Texas field offices reported that at the beginning of the demonstration, the DSU was giving the field office leads instead of appointments, requiring the field office to call the clients. This was apparently because DSU workers were giving clients appointment times but not properly entering the appointments into the field office scheduling calendar. This error became more of a problem as the volume of clients picked up after later, larger mailings. Although the Orlando field office reported that the problem was eventually corrected, the Corpus Christi field office reported having occasional problems throughout the demonstration period.
- In Miami, Florida, differences in terminology between the SSA field office and the state Medicaid agency initially caused confusion about QI-1 applications. State Medicaid staff referred to QI-1 clients as Part B Medicare Only (PBMO).

#### **D. Widow(er)s Model Site**

In the widow(er)s model, field offices were originally told to set up telephone appointments with MassHealth, the state Medicaid agency, if clients had questions regarding the application and if they called between 9:00 A.M. and 4:00 P.M. The MassHealth Enrollment Centers (MEC) do not conduct in-person interviews because there are only four Center locations in the state, making it difficult for many clients to access them. Consequently, the field offices were to mail or give the screening letter and application packet to the client, and the client was to mail the application to the MEC.

MassHealth later indicated that it preferred that the field offices stop setting up appointments with MassHealth altogether and instead instruct the client to contact MassHealth between 9:00 A.M. and 4:00 P.M. if they had questions about the application. This approach was later made the standard procedure for the widow(er)s model throughout Massachusetts.

The initial use of a short-form application for premium-only benefits (i.e., QI-1 or SLMB) in the widow(er)s model (discussed in Chapter 3) created concerns that the demonstration process was putting clients in a disadvantageous position, which led to procedural changes later. The concerns grew from the requirement that clients seeking QMB benefits must use the standard long Medicaid application. The state did not initially provide these standard long forms to the field offices. Therefore, a beneficiary who applied for premium-only benefits using the short form but who was eligible for the more generous QMB benefits would not be approved for these additional benefits (i.e., coinsurance and deductibles). In mid-September 1999, the state began sending letters to this group, informing them of the additional benefits for which they might be eligible. The state already had a system in place to review applications and identify and enroll beneficiaries who applied for QMB benefits and did not qualify, but who did qualify for the lesser premium-only benefits.

For the demonstration, SSA and the state eventually agreed that these long forms would be distributed to all field offices. Procedures for QMB enrollment became a standard part of the widow(er)s model in mid-September 1999.

### **III. ADDITIONAL BARRIERS TO COMPLETING APPLICATIONS**

Several factors could intervene, after a beneficiary has been screened, to prevent the beneficiary's applying for benefits or to complicate the administrative picture for the agencies involved. These factors include:

- Communication problems between screening staff and application staff;
- Backlog or unavailability of application appointments;
- Lack of transportation or mobility; and
- Clients' feelings about the state Medicaid agency and welfare, including relative unfamiliarity with the state Medicaid agency as well as the welfare stigma that clients might associate with the state Medicaid agency or the Buy-in benefit.

Section II discussed the role of communication problems. The remaining potential barriers are summarized in *Exhibit 6.3* and discussed below. The exhibit relies largely on staff impressions of the above factors. We have little empirical evidence of these effects. We hope to include in the interim report information from some of the states' application logs on no-show rates and state electronic data on applications by model and site. The rate of no-shows for application appointments could be the result of scheduling errors, transportation and mobility problems, clients' attitudes, or a combination of these. Combining the information gathered from our interviews with the no-show data might provide clues about which of these effects predominate. Thus, the information captured in *Exhibit 6.3* and described below will provide context for our full process evaluation.

#### **A. Scheduling Difficulties and Unavailability of Application Appointments**

Most demonstration sites reported a large volume of application appointments following mailings, resulting in appointment backlogs of up to one month. Interestingly, the Lebanon, Pennsylvania state Medicaid agency did not report such an effect, despite a similar volume of Buy-in inquiries at several other sites that did report backlogs. This might be the result of high no-show rates.

Several sites had to add application appointment slots to accommodate the demand. This was particularly true for application model sites, which were responsible for scheduling and handling the applications themselves. In addition, the Evansville, Indiana field office reported that many of their clients who had called the Spanish line at the DSU complained that they could not get an application appointment.

## Exhibit 6.3

## Potential Barriers to Completing Applications at Each Site

Sites by Model	Application Appointment Backlog and Availability <sup>a</sup>	Method of Application Submission	Public Transportation in Area	Clients' Feelings about State Medicaid Agency
<b>Screening Model</b>				
Carlisle, PA (Cumberland County)	<ul style="list-style-type: none"> <li>• Appointments one month out</li> <li>• Scheduling 3 weeks out</li> </ul>	In person or by telephone	No regular bus service; must register	Several clients turned around and left after discovering that benefit was through state Medicaid agency. DPA (state Department of Public Assistance) sent out a letter with appointment time and application. This letter was on DPA letterhead and might have increased no shows.
(Perry County)			None	
Lebanon, PA (Lebanon County)	<ul style="list-style-type: none"> <li>• Little effect</li> </ul>	In person or by telephone	None	Field office manager felt strongly that screening model would not work because of welfare stigma in this community. She mentioned that DPA was reporting many cancellations and no-shows to application appointments. Although clients were enthusiastic about the benefit, they did not want to visit the "welfare office."
<b>Co-location Model</b>				
Muskogee, OK (Muskogee, Cherokee, Adair, Wagoner and McIntosh County)	Had small backlog during peaks only	In person or by telephone	None	Field office manager remarked that many elderly have had a bad experience with the welfare office in the past and will not go there.
Oklahoma City, OK (Oklahoma County)	Difficulty fitting appointments into P/E calendar. Had as many as 40 appointments in one day.	In person or by telephone	Bus service	Unclear from interview materials.
Uniontown, PA (Fayette County)	2-3 week backlog at peak	In person or by telephone	Local, but not outside of town	Field office reported strong anti-welfare feeling among clients. If clients had to call welfare office for some reason, they did not want to pursue it.
West Chester, PA (Chester County)	Not much backlog	In person or by telephone	Bus service	Field office reported that anti-welfare sentiments were common among clients. Many were irritated when they discovered the nature of the benefit. However, most stayed to complete the application if they had already begun.

Exhibit 6.3— Continued

Sites by Model	Application Appointment Backlog and Availability <sup>a</sup>	Method of Application Submission	Public Transportation in Area	Clients' Feelings about State Medicaid Agency
<b>Application Model</b>				
Miami, FL ( <i>Dade County</i> )	Had appointment backlog.	In person or by telephone	Extensive bus service, well used.	No particular issues noted.
Orlando, FL ( <i>Orange and Osceola County</i> )	No backlog; well-staffed	In person or by telephone	Extensive, well-used bus service. Goes to SSA field office and state Medicaid agency	Some recertification individuals do not like the fact that they must come to the Families and Children office for recertification. Most clients thought the Buy-in benefit was a great idea. Only a small minority refused to take it because it was welfare. Some clients also complained long waits at Medicaid agency turned off clients. Preferred to deal with SSA, because of familiarity.
Lexington, KY ( <i>Fayette County</i> )	It took 3 to 4 weeks to get back to normal. At outset, not enough appt slots – more added.	In person; by telephone if necessary.	Bus service	Field Office manager observed that clients preferred coming to SSA office over state Medicaid agency, even though it is a nice office in a nice location. She speculated that this was because the Medicaid agency was crowded. Did not offer welfare stigma as an explanation, but thought it plausible when mentioned.
Corpus Christi, TX ( <i>Nueces County</i> )	It took 2 weeks to return to normal. Added staff to keep up.	In person, or by phone (signature page could be mailed to the client if s/he could not come in)	Very limited, not used.	A misunderstanding of a Texas law on Medicaid "estate recovery," recently in the news, had many clients worried that accepting Buy-in benefits could result in the state's taking away their property.
<b>Widow(er)s Model</b>				
Massachusetts ( <i>All Counties</i> )	Little volume, no backlog	By mail allowed and preferred.	Depends on county	Unclear from interview materials.

Source: The Lewin Group interviews with field office and state Medicaid agency staff.

<sup>a/</sup> Appointment backlog refers to the length of time between a client's screen and his/her application appointment/submission.

It is possible that clients who are forced to wait a considerable period of time between screening and application might be less likely to actually apply than those whose applications are taken immediately or soon after they are screened. If so, the backlogs and scheduling difficulties reported by many demonstration sites might have reduced the proportion of clients who would have eventually received Buy-in benefits.

## **B. Lack of Transportation or Mobility**

Almost half of the demonstration sites reported that their areas lacked adequate public transportation. A lack of public transportation might make it harder for seniors and disabled Medicare beneficiaries to get to a field office or state Medicaid agency for an application appointment. All sites indicated that they accommodate clients who cannot travel to an in-person interview in some way. Depending on how accommodating the states are (e.g., whether they push clients to come into the office and only allow a telephone interview or home visit under extreme circumstances, or give the client the option), the combination of transportation limitations and state application requirements could dissuade clients from completing their applications.

## **C. Clients' Feelings about the State Medicaid Agency**

Clients' attitudes about welfare and the agency that administers programs they consider welfare can strongly affect their decision to seek benefits from that agency. Many Medicare beneficiaries might have a negative view of welfare benefits and would not accept a benefit they consider welfare. Others might not want to interact with an unfamiliar agency.

Interviews with field office and state Medicaid agency staff provided substantial anecdotal evidence to support the existence of all the attitudes listed above in at least some communities. Field office staff at most demonstration sites reported some degree of ill feeling on the part of clients toward benefits associated with welfare or with the possibility of having to interact with the state Medicaid agency. These feelings seemed strongest in the screening model sites. Both screening model field offices reported that clients were generally unhappy to learn that they had to go to the state welfare office to apply for the benefit. The Carlisle, Pennsylvania site reported that several clients actually turned around and left after discovering this.

Client reaction varied across the co-location model sites. The West Chester, Pennsylvania field office reported that anti-welfare sentiments were common among clients. Many were irritated when they discovered the nature of the benefit, but most stayed to complete the application if they had already begun. This might be a predominant view in that geographic area, considering that the two screening model sites that reported similar attitudes also were in Pennsylvania.

The two Pennsylvania co-location model sites reported similar anti-welfare feelings among their client base. The co-location model field office manager in Muskogee, Oklahoma, did not cite welfare stigma per se but offered that many clients have had bad experiences in the welfare office and do not feel comfortable going there. The lack of overt signs of anti-welfare attitudes among the Muskogee client base might be regional and might also be related to the way this particular co-located worker described his role to his clients. The Muskogee co-located worker reported that most clients thought of him as an SSA employee and not a welfare worker.

Application site field offices also observed indications of possible welfare stigma but suggested that discomfort in dealing with the state Medicaid agency might be just as large or larger a factor affecting Buy-in enrollment. The Orlando, Florida demonstration coordinator said that most applicants felt positive about the benefits but that some clients were hostile to a welfare benefit, although this was rare. Field office staff at Orlando and Lexington speculated that clients did not like dealing with the state Medicaid agency because it was crowded and had long lines. Finally, officials in both Corpus Christi, Texas, and Evansville, Indiana, added fear of losing one's home as a possible deterrent. Both states had Medicaid estate recovery laws on the books and reported that many clients were mistakenly worried that accepting Buy-in benefits could allow the state to take away their property.

#### **D. Interaction of State Application Requirements and Other Barriers to Applying for Buy-in Benefits**

Certain combinations of state application requirements might create particular problems or opportunities for specific model approaches. For example, if it is true that clients, for whatever reason, have misgivings about going to the state Medicaid agency to apply for Buy-in benefits, the screening model will work less well should clients be required to visit the state Medicaid agency in person. If clients also have misgivings about contact with the state Medicaid agency or if they have negative attitudes about receiving welfare, even allowing telephone interviews with the state Medicaid agency might not persuade these clients to apply. However, if a state developed a simple short-form application that can be filled out without supervision or assistance and can be mailed to the state Medicaid agency, the screening model might work well even in the face of negative feelings about welfare or unfamiliarity with the state Medicaid agency.

Conversely, if clients are allowed to mail in the application without supervision but the application has not been simplified, clients might be discouraged from applying at all, particularly elderly or infirm clients in need of greater assistance.

#### **IV. APPLICATION SUBMISSION PROCESS AT THE APPLICATION MODEL SITES**

Because the application model involved the use of a non-state worker to take an application for a state program, it had the greatest potential to create problems for the state's adjudication process. Clear communication is probably most critical in the application model sites because the field office must understand what the state needs to efficiently adjudicate the application. Application model sites reported good relationships between the field office and the state Medicaid agency and felt that the demonstration brought the field office and the state Medicaid agency closer together. Although demonstration staff felt that the application model worked well and ran smoothly, the application model sites experienced some missteps as the SSA field office learned how to meet the state's requirements:

- At the beginning of the demonstration, the Orlando, Florida field office was initially attaching the screening tool summary sheets in lieu of filling out certain parts of the application, unaware that the DSU screenings were often missing fields because clients were uncomfortable giving certain information over the telephone. When the state Medicaid agency discovered this problem and communicated it to the field office, the field office

dispensed with the summary sheets and made sure to enter complete data into the applications.

- Many of the Corpus Christi, Texas field office's applications were also incomplete, resulting in part from a lack of clarity about the level of documentation required for adjudication and in part from differences between SSA and state philosophies. It appears that the field office did not learn that the state accepted client declaration on its Buy-in applications until the evaluation team site visit meeting on June 23, 1999, two months after the first application model mailing. Because the state accepted client declaration, adjudication was often possible without re-contacting the client, as long as enough information was provided on the application (e.g., the declared value of an insurance policy). The incomplete applications from the field office caused the state's adjudication times to increase because it re-contacted these clients. After discussion with the state, the field office agreed to push clients for estimates if they were unsure of the exact amount. The acceptance of income and resource information without verification was a practice unfamiliar to SSA claims representatives (CR) in their normal SSA eligibility determination work.
- Also in Corpus Christi, at least a dozen clients had their application taken twice. The field office was unsure how these redundant application appointments were scheduled. Their occurrence during a period of particularly high activity in July 1999 suggests that the problem might have been related to or exacerbated by the high demand on the DSU and/or the field office.
- At the outset of the demonstration, the Evansville, Indiana SSA field office was taking applications for clients deemed ineligible as well as for those screened as potentially eligible. This was rectified early in the demonstration.
- The Miami, Florida and Lexington, Kentucky field offices reported no significant problems with the application process.

## **V. IMPACTS OF APPLICATION REFERRAL AND SUBMISSION ON SOCIAL SECURITY ADMINISTRATION FIELD OFFICE STAFF WORKLOADS**

Application-related activities affected field office workloads differently by model type and, therefore, are discussed below by model. Several field office managers noted that the demonstration generated a large amount of administrative work for them and for the office in general. Some of this work related specifically to demonstration tracking activities that might not exist under an actual program. These include keeping manual application logs and time logs as well as work generated as a result of confusion between models (i.e., scheduling errors made by the DSU).

For the interim report, we will combine the information below with estimates of management and administrative time spent and screening-related workloads to estimate administration costs associated with the four Buy-in outreach models.



## **A. Screening Model**

The screening model field offices spent more time than other sites on scheduling application appointments for clients. Only the screening model field offices had to coordinate with the state Medicaid agency to schedule application appointments for walk-in clients. As described in Section II, the effort this required could vary significantly depending on the reliability of the field office's contact(s) at the state Medicaid agency.

Screening model sites were also forced to deal with application scheduling errors made by the DSU, even though it took no applications, because the DSU occasionally confused screening model sites with other models and scheduled application on their P/E calendars.

## **B. Co-location Model**

The co-located Medicaid worker was not a field office employee, and, therefore, does not factor into a measure of field office workload. In sites where the co-located worker also performed some screening activities for walk-ins, the impact of the Buy-in outreach on field office staff was lesser still. The co-located worker also served as a liaison between SSA and the state Medicaid agency, possibly reducing the likelihood of work-generating communication problems between the agencies.

## **C. Application Model**

Because the application model gave application-taking responsibility to the field offices, the application model had the largest impact on field office workloads. *Exhibit 6.4* presents data derived from time logs kept by each of the application model sites. The table contains information about the volume of applications submitted and total and average time spent by field office staff on application interviews. The table also contains information about overtime used in the field office during the demonstration period, gathered from interviews with field office staff and provided as a measure of the burden imposed by the application process.

The average amount of time spent on application interviews was 24 minutes but ranged from 13 minutes at the Miami, Florida field office to 35 minutes at the Corpus Christi, Texas field office. The long interview times in Corpus Christi were probably at least in part because of the cumbersome set of forms used in the interview. Corpus Christi application workers filled out two forms concurrently during the interview. One was the four-page, statewide short form developed for the Buy-in, and the other was a two-page guide to the form that the interviewer was also required to fill out. These forms had many overlapping fields but were not identical, and filling out both involved referring back-and-forth between the two forms.

It is unclear why Miami's application interviews were much shorter than even Orlando, Florida's, which used the same application form. This also could be partly related to the characteristics of the beneficiaries applying in Miami. If their finances were more straightforward than those of clients in Orlando and other sites, their application interviews might have required less time.

**Exhibit 6.4****SSA Field Office Workload Associated with Taking Applications**

<b>Application Model Sites</b>	<b>Total Number of Applications</b>	<b>Total Minutes Spent Taking Applications</b>	<b>Average Minutes per Application</b>	<b>Burden on Field Office</b>
Miami, FL ( <i>Dade County</i> )	466	6,274	13	Overtime used.
Orlando, FL ( <i>Orange and Osceola County</i> )	2,492	53,277	21	Some overtime used. Also had people four detailee during demo period.
Evansville, IN ( <i>Vanderburgh County</i> )	559	15,053	27	Overtime used.
Lexington, KY ( <i>Fayette County</i> )	510	10,389	20	Overtime used (about 100 hours). Other work disrupted. Took 3-4 weeks to return to normal.
Corpus Christi, TX ( <i>Nueces County</i> )	1,048	37,021	35	Overtime used (493 hours). Other work disrupted. Took 2 weeks to return to normal.
<b>Totals</b>	<b>5,075</b>	<b>122,014</b>	<b>24</b>	

Source: Application time data from SSA central staff, compiled from time logs provided by application site field offices. Overtime information from interviews with SSA field office staff conducted by The Lewin Group.

All five application site field offices used overtime during the demonstration period and noted that much of this overtime related to application taking or other demonstration activities. The demonstration nevertheless had a more disruptive effect on some offices than others. The Lexington, Kentucky and Corpus Christi, Texas field offices reported significant disruption to other field office work. The Lexington office appeared to be the most affected, estimating that it was three to four weeks after a mailing before workloads returned to pre-mailing levels. In contrast, Orlando, Florida, reported no disruption to other field office work. The Orlando field office is the largest SSA field office in the country and was well staffed at the outset of the demonstration.

Several field office managers noted that, in addition to the screening and application work generated by the demonstration, the demonstration generated a large amount of administrative work. For example, the Lexington, Kentucky field office manager emphasized that the workload included not just the application taking itself, but the paperwork, scheduling, logging-in and tracking of interview times, and documenting of the applications sent to the state. The West Chester, Pennsylvania field office felt that the results of the outreach in their community did not justify the additional work generated. It is important to note, however, that much of this additional work related to the demonstration rather than the program itself. If a nationwide program were implemented for all SSA field offices, automated reporting systems could be developed and standardized to keep track of clients and their information.

## **D. Widow(er)s Model**

At first glance, it might appear that the field offices that conducted the widow(er)s model demonstration experienced the least amount of work as a result of the demonstration. The state Medicaid agencies in Massachusetts, where the model was carried out, preferred not to schedule appointments, obviating the need for field office staff to coordinate with the Medicaid agency in scheduling appointments. In addition, screening volume was much lower in widow(er)s model field offices than in others, so the demonstration created fewer disruptions to other field office work than under other models.

However, it was precisely this low volume that made the widow(er)s model an administrative burden for the field offices involved. Compared to the small number of Buy-in applications generated by the demonstration at any one field office, the amount of preparation and administrative work the demonstration required was large. In addition, the number of changes to the original approach that were made during the course of the demonstration added to the administrative burden (see Chapter 3 for a description of these changes).

## **VI. WORKLOAD IMPACTS ON STATE MEDICAID AGENCIES**

In all demonstration sites, as soon as the field office referred the client, the state assumed responsibility for adjudication and annual recertification of eligibility. In addition, in all but the application sites, the state Medicaid agency also had to take the application. The demonstration increased workloads, in some cases dramatically, for the state Medicaid agencies responsible for processing the Buy-in application of the clients referred from the corresponding SSA field offices. However, the effect on workloads varied somewhat by agency.

*Exhibit 6.5* displays two measures of the workload impact of the demonstration on the state Medicaid agencies. All but one of the agencies at application model sites used overtime during the demonstration period, although most of the other agencies did not. In addition, the Nueces County Medicaid agency in Corpus Christi, Texas, used a significant number of overtime hours and had to distribute the applications among several other Medicaid offices in the area to get them adjudicated within their processing time requirements.

As previously mentioned, Medicaid agencies are required to meet processing time standards for new benefits. These standards are usually defined as 30 or 45 days between the day a client first applies and the day the client is approved for benefits. Most agencies saw increases in their processing times but still stayed within their standards. A common complaint was a lack of funding for the additional work.

Several aspects of the demonstration created possible inefficiencies or difficulties for the Medicaid agencies. For example, in the application sites, some state Medicaid agency staff felt that having the SSA field office take applications did not save the state agency time and might actually have created work because the state agency usually had to spend extra time contacting clients to obtain additional evidence required for adjudication. Also, some agencies felt that the denial letters generated by the screening tool gave beneficiaries false hope by claiming that the Medicaid agency might have other benefits for which the beneficiary might be eligible. State

Medicaid agency staff would have to tell those beneficiaries who contacted them that no such benefits existed.

### Exhibit 6.5

#### Impact of Applications on State Agency Workloads and Adjudication Backlog

Sites by Model	State Agency Overtime	Impact on State Processing Times
<b>Screening Model</b>		
Carlisle, PA (Cumberland County) (Perry County)	None	20 percent volume increase, but not out of compliance No issues
Lebanon, PA (Lebanon County)	None	Stayed within standards
<b>Co-location Model</b>		
Muskogee, OK (Muskogee, Cherokee, Adair, Wagoner and McIntosh County)	None	None
Oklahoma City, OK (Oklahoma County)	Worked a lot of extra hours, but were granted only small amount of overtime.	Hired summer worker to stay within standards
Uniontown, PA (Fayette County)	None	Stayed within standards
West Chester, PA (Chester County)	None	Stayed within standards
<b>Application Model</b>		
Miami, FL (Dade County)	None	Absorbed additional applications in normal workload
Orlando, FL (Orange and Osceola County)	Some Saturday overtime	No new staff, big addition to daily workload; 1,600 additional applications which is equivalent to an additional unit, but stayed within processing standards  Field office noted in January 2000 that some clients who applied in July were still waiting for their benefits.
Evansville, IN (Vanderburgh County)	Yes	Stayed within processing standard.
Lexington, KY (Fayette County)	Yes	Particularly large numbers in December because of SLMB and QI recertification.
Corpus Christi, TX (Nueces County)	Used overtime (e.g., 180 hours in one week), and farmed 93 applications to other Texas Dept. Of Human Services offices	Lengthened process times, but stayed within 45 days.
<b>Widow(er)s Model</b>		
Massachusetts (All Counties)	None – low volume	None

Source: The Lewin Group interviews with state Medicaid liaisons.

In Massachusetts, which conducted the widow(er)s model statewide, regional MECs were responsible for taking applications. However, a single MEC, in Tewksbury, was responsible for

adjudicating all the applications generated by the Buy-in demonstration statewide. Even with the entire state's applications, the Tewksbury processing times were not dramatically affected. This was because through September the widow(er)s model did not produce large increases in enrollment statewide.

## **VII. RECERTIFICATION**

Unfortunately, concerns about access to Buy-in benefits do not end when a beneficiary has been enrolled and is receiving Buy-in benefits. This is because states require annual redetermination, or recertification, of eligibility for Buy-in. The state recertification process reintroduces some of the barriers that the demonstration attempted to remove.

The recertification process requires that the beneficiary interact with the state Medicaid agency. The co-location and application models aimed to increase enrollment in part by allowing beneficiaries to avoid contact with the state Medicaid office. Also, by associating the benefit with the SSA field offices, all models might have reduced some of the stigma that some clients associate with Medicaid benefits. It is possible that some, or even many, clients might refuse to submit to recertification and consequently lose Buy-in benefits.

Recertification will likely be a larger problem in states that require in-person recertification. Of the demonstration states, Florida, Kentucky, and Pennsylvania reported requiring in-person interviews for recertification.

In Florida, recertification of demonstration participants might also result in more clients' losing Buy-in benefits because at initial application the states accepted client declaration of income and resource information for Buy-in benefits (i.e., in states where clients may be approved without verification of the income and resource information they provide) but will require evidence and verification at recertification. Not surprisingly, then, staff at the Orlando, Florida field office and the Orange County and Osceola County Medicaid agencies were particularly concerned about recertification. The Orlando field office collected information for the majority of their applications by telephone, and client declaration was accepted in determining eligibility for benefits. Because Florida requires in-person recertification and requires verification of income and resources at recertification, staff at both the field office and the state Medicaid office expect many beneficiaries to lose their Buy-in benefits at recertification. Florida performs their recertifications for SLMB and QI-1 every January. Thus, beneficiaries who have recently applied for Buy-in, including some who have not yet receive the increased payments in their Social Security checks, might lose their benefits shortly after being approved for them.

## **VIII. STAFF IMPRESSIONS**

Demonstration staff offered the following impressions related to the Buy-in application process:

- Oklahoma City, Oklahoma and Lexington, Kentucky field offices suggested that the appointment calendar be adapted to better fit the Buy-in program. Specifically, the number of application time slots must be expanded.
- Some staff from the state Medicaid agency in Vanderburgh County (i.e., the Medicaid agency for the Evansville, Indiana field office) felt that SSA should either develop evidence

to the point where the application is ready for a decision or leave the entire application interview and adjudication process to the state Medicaid agency. These individuals thought that the outreach was valuable but that the process was not at all efficient. The Lebanon County, Pennsylvania (Carlisle field office) and Miami, Florida state Medicaid agency staff also commented on the value of the outreach efforts but noted that involving SSA in the application process was inefficient. Some application staff at the Miami SSA field office felt the same way.

- Staff at several field offices commented that improved training or monitoring of the DSU staff might have helped them avoid some of the scheduling and referral difficulties. Some of these issues might be minimized if the DSU staff were not required to deal with multiple processes related to different models.

## **CHAPTER 7: SYNTHESIS AND LESSONS LEARNED IN THE DEMONSTRATION**

To prepare for this report, The Lewin Group conducted extensive interviews with the Social Security Administration and state Medicaid agency staff and reviewed SSA site visit reports. The information collected from this field research indicated that the four demonstration models were implemented as intended. As expected, each site adapted the model to fit the field office and state Medicaid agency's staffing levels and organizational structure. We do not expect differences in implementing the demonstration to affect the impact analyses. However, if large unexplained differences emerge by site, we will need to revisit this assessment.

The site's experiences in implementing the models provide valuable information that should be considered before expanding one of these models to other communities. This chapter begins with a list of suggestions offered by staff regarding their experience. Then it offers other issues for consideration.

### **I. STAFF OBSERVATIONS**

#### **A. Local Freedom in Implementation Strategy**

Many field office and state Medicaid agency staff appreciated that they were given a significant amount of latitude in implementing the demonstration in their communities. The speed with which the demonstration was taken from concept to implementation in the field was the principal reason for the high level of freedom afforded local staff.

#### **B. Commitment from Major Players**

Commitment from high-level SSA officials, evidenced by the speed with which the demonstration was implemented, played a major role in the demonstration's success. All offices that had a hand in the demonstration made its implementation a priority.

#### **C. Evidence of Welfare Stigma Observed during Screening Process**

Some screeners, both at the Direct Service Unit and at the field offices, reported talking to clients who expressed disappointment when they learned that the welfare office was involved. Several DSU screeners reported having clients lose interest in the benefit as a result. However, most field office screeners whose clients expressed disappointment about welfare office involvement reported that these clients usually completed the screening process.

#### **D. Need for Uniformity for a National Effort**

Several field and central office staff noted that if the process were used nationally, processes and forms would have to be uniform and integrated into the current electronic scheduling and forms systems.

## **II. CONSIDERATIONS FOR BROADER IMPLEMENTATION**

The experiences SSA and state Medicaid agency staff had implementing and operating the four demonstration models provide several lessons that program staff would find valuable if they plan to implement these approaches nationwide. The key issues are discussed below.

### **A. Communication between the Social Security Administration Field Office and the Local Medicaid Agency**

The most common theme that arose in conversations with field office and state staff was the need for clear communication among all parties involved in the effort. This includes regular communication between the SSA field offices and the state agency responsible for adjudicating client applications. Because eligibility requirements, application procedures, and standard means of client contact (e.g., in person, by telephone, and by mail) differ by state, each field office must establish a relatively close working relationship with its respective state agency.

### **B. Well-Defined Liaison Role**

Coordination of a program that adds novel activities to the daily practices of field offices and state agencies and that seeks cooperation across these offices requires that coordination staff (e.g., central office staff or other staff responsible for overseeing the outreach program nationally) be given a clearly defined liaison role. In the demonstration, it appeared that some central office staff took on the role of liaison/troubleshooter to a greater degree than did others. Such a role, regardless of who fills it, would help ensure that inevitable implementation problems are resolved efficiently. It would also help ensure that offices are trained consistently.

### **C. Accountability**

It is also important to establish accountability on the part of the field offices that participate in the outreach effort. This is particularly true in the widow(er)s model, where field office staff were entirely responsible for all outreach and identification of clients appropriate for screening. With no additional funding for the effort and maximum control over the amount of work generated, field offices might have had an incentive to limit their effort.

Accountability becomes another issue for the co-location model, where the success of the model resides with the responsibility and determination of the co-located worker; however, this worker is not accountable to SSA. One field office manager noted that the model was working well in this office, primarily because of the co-located worker's sense of responsibility and hard work. The model might not have been as successful with a less dedicated worker.

### **D. Adequate Training for Social Security Administration Staff**

If SSA staff assume responsibilities previously belonging to the states, such as taking Medicaid applications, it is imperative that the local Medicaid offices take the time to train field office staff in the rules, requirements, and accepted practices of applying for Buy-in benefits for all aspects of the application and adjudication process to minimize misunderstandings. SSA staff should also abandon preconceived notions regarding application processes (e.g., Title XVI) based on their own experiences because they could cause misinterpretation of state policies.



## CHAPTER 8: ANALYSIS PLAN FOR INTERIM AND FINAL REPORTS

This chapter outlines our analysis plans for the interim and final reports based on our understanding, to date, of the demonstration sites and the data we will have available. Section I of the chapter begins by outlining the key research questions we hope to investigate. Section II presents the data sources that will be used for the analyses. Lastly, Sections III and IV discuss the components of the interim and final reports, respectively.

### I. RESEARCH QUESTIONS

Based on our understanding of the Buy-in program and the demonstration, we offer the following research questions to be investigated through the process and impact evaluations:

- Are there differences in the response rate to the letters, the percent screened to be eligible, the application rate or the enrollment rate by site or by model? Differences by site or by model might occur because of differences in implementation, beneficiaries' perceptions of the models, or characteristics inherent to sites.
- Do individuals with certain characteristics have higher screening rates? Our initial tabulations indicate that individuals with a preference for Spanish or who were screened in Spanish had higher screening rates. This might indicate greater success of the outreach efforts with this population. However, it might also be that this population has lower Primary Insurance Amounts (PIA) or monthly Title II benefits, resulting in a greater likelihood of being screened.
- Do demonstration sites have a larger increase in enrollment from the pre- to post-periods than the comparison areas? A statistically significant increase in enrollment in the demonstration sites would indicate the demonstration had an effect.

### II. DATA

For the analyses of the screening, co-location, and application models, we will use four data sources for our impact analyses: Social Security Administration's Master Beneficiary Record (MBR) data, screening data, state-provided Medicaid enrollment data, and 1990 Census data. *Exhibit 8.1* details the relevant data elements and their use in the analyses. We note that the screening data are unavailable for the comparison sites or for anyone who did not respond to the letter or other outreach. The data will be used primarily for the process evaluation.

**Exhibit 8.1****Data Elements and Uses Available from Alternative Sources**

<b>Data Element</b>	<b>MBR</b>	<b>Screeners</b>	<b>State Medicaid Data</b>	<b>1990 Decennial Census</b>
<b>Matching/Edit Variables</b>				
Social Security number/BIC	X	X	X	
HIC number			X	
Claim number	X			
Name (first, MI, last)	X	X	X	
Date of birth	X		X	
Date of death	X			
Sex	X	X		
State	X	X	X	
County				X
ZIP code	X	X	X	
Title XIX entitlement code	X		X	
Hospital Insurance (Part A)	X	X		
<b>Explanatory Variables</b>				
Age (calculated based on DOB)	X		X	
Race	X			
Sex	X	X		
Marital status		X		
Language preference	X	X		
Monthly benefit credited/poverty guideline	X	X		
Type of claim	X			
Benefits directly deposited	X			
% in county in poverty				X
% living alone				X
% with limitations in personal care				X
% without a vehicle				X
<b>Process Variables</b>				
Date of Medicaid application			X	
Reason for denial			X	
Resources by type for self and spouse		X		
Income by type for self and spouse		X		
Interview length		X		
How learned of program		X		
Passed screen		X		
<b>Outcome Variables</b>				
Medicaid application status			X	
Medicaid enrollment category			X	

## **A. Medicaid Application Data**

Only Oklahoma and Pennsylvania will provide application data for both the historical and post-demonstration periods.<sup>36</sup> Pennsylvania data will include a status code (i.e., denied, approved, or pending) but not denial reason codes. Texas is not able to provide application data at this time but might be able to at a later date (the state is creating a data warehouse). We think these data will be unavailable during the term of this contract.

The remaining states will have individual-level application data for the post-demonstration period, with the following qualifications:

- Florida can supply Qualified Medicare Beneficiary (QMB) application data, but not Specified Low-Income Beneficiary (SLMB) and Qualified Individual 1 (QI-1), which comes from another system. The state will be able to provide denial reason codes for QMB records.
- Indiana can supply a file containing application data (dates and denial reason codes) for the demonstration site (Evansville field office, Vanderburgh County) only.
- Massachusetts will supply application records for those screened by the field office and tracked by the state. They will not include denial reason codes.
- Kentucky should be able to supply post-demonstration application data, including denial reason codes.

Note that many states are keeping application logs with information on the application experience of individuals screened for the Buy-in demonstration, which have been requested to validate the electronic data from the state. The formats range from paper logs to electronic spreadsheets. Section IV.D.1 of this chapter discusses the implications of the data available from the states for the analyses.

## **B. Medicaid Enrollment Data**

All states, except Massachusetts and possibly Kentucky, will provide individual-level enrollment data for both the pre- and post-demonstration periods. Massachusetts will provide enrollment information for individuals who have been screened at the field offices and tracked by the state.

At the minimum, we will capture the following data fields:

- Social Security number (SSN)
- Name
- Date of birth (DOB)
- Zip code

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<sup>36</sup> At the time of this report, it was unclear whether Oklahoma or Kentucky would supply data or whether Health Care Financing Administration (HCFA) data would have to be used. If we must rely on HCFA data, we will not have application data for Oklahoma.

- Date of enrollment or approval
- Medicaid program category

For Florida, Oklahoma, and Pennsylvania, we will receive enrollment data covering all Medicaid categories for all Medicare beneficiaries. For Indiana, we will have records on recipients of QMB, SLMB, and QI-1 benefits and will know whether these recipients received other Medicaid benefits, as well (i.e., were fully covered). Texas will send QMB plus, QMB, SLMB plus, SLMB, and QI-1 enrollment data.<sup>37</sup>

Massachusetts will provide us an updated Excel spreadsheet that contains all referrals from the field offices that are being tracked by the state Medicaid agency. Data points included in the referrals are application status, date of determination, and Medicaid program (QMB, SLMB, QI-1, or Qualified Individual 2 [QI-2]). The State of Massachusetts is providing individual-level data regarding the disposition of applications for all individuals referred by a field office and identified as part of the demonstration by a letter.

Unfortunately, the State has approximately half as many “participants” in its system compared with the number of screenings generated by the field offices. As previously mentioned, the field offices are responsible for faxing or mailing a copy of the letter generated by the screener program to the Tewksbury MassHealth Enrollment Center (MEC) after screening a widow(er). Staff at Tewksbury log the screened individual and keep track of his or her benefit status. The extent to which this log contains all individuals depends on 1) whether field office staff remember to fax or mail the letter to the correct MEC (or at all) and 2) whether the Tewksbury staff enter the information into their tracking log. This issue will require further investigation. The lack of a comparison site, pre-period data, unless the Health Care Financing Administration (HCFA) data become available, and the low participation rate present challenges for estimating the impact of the widow(er)s model.

### **C. Health Care Financing Administration Data**

We hope to obtain two sources of data from HCFA: 1) information at the individual level regarding enrollment in Medicare+Choice plans in the study states from the Group Health Plan Master File; and 2) information from the Third Party Master File to provide individual-level data on Buy-in enrollment for states that are unable to provide this information (Massachusetts and, possibly, Kentucky and Oklahoma). Obtaining the Medicare+Choice enrollment provides another relevant explanatory variable for Buy-in participation. Although individuals in Medicare+Choice plans must pay the Part B premium, they often are provided fairly generous supplemental benefits without having to pay an additional premium. This might reduce the need to apply for Buy-in benefits. The Third Party Master File might be a poor substitute for Medicaid Management Information System (MIS) data on Buy-in enrollment; however, state-submitted data might lack the accuracy of detail for the type of Buy-in beneficiary. We will need to explore issues related to classification with state officials, particularly for the pre-period.

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<sup>37</sup> QMB plus and SLMB plus recipients receive other state-offered Medicaid benefits in addition to Part B premium payments and Medicare cost sharing.

### III. INTERIM REPORT

The interim report will consist of the process evaluation material presented in this report, updated descriptive analyses, and further elaboration on the process evaluation based on the information added in the descriptive analysis.

As the first several chapters of this preliminary report demonstrate, the process evaluation will provide a number of benefits to the overall demonstration and to SSA. Briefly, the process/implementation analysis has the following goals:

- Clarify the influence of other factors (community or context variables) that might affect program success.
- Describe the characteristics of the agencies, organizations, and others involved and their overall approach to the demonstration.
- Describe program operations, creating a context in which to interpret and explain outcome study findings.
- Determine if each demonstration model is being implemented as SSA intended, and if not, understand the factors that brought about changes.
- Provide insight for program refinement.
- Obtain feedback from the staff operating the program at the local level regarding their experiences with program implementation and operation.
- Assess specific program components.
- Identify lessons from the implementation and operation experiences that might assist with future replication efforts.
- Quantify and document basic program operations.

We would like to add the following components to complete the process evaluation:

- A participant/non-participant analysis
- An analysis of undelivered letters
- An analysis of no-show rates for appointments
- An adjudication analysis, including approvals and reasons for denial
- A time flow analysis

These analyses will provide a more complete picture of the process from screening to adjudication. Although these analyses might suggest evaluation outcome, all focus on the demonstration sites and will not provide definitive information regarding the impact of the evaluation.

We will use the findings of the process study to understand and explain the factors that influence the outcomes achieved by the demonstration. We will examine the site-to-site variation in outcomes, in light of noted site-to-site differences in programs, to further validate our observations about the relationships between program features and the outcomes achieved.

### **A. Participant/Non-participant Analysis**

Certain outreach efforts might be more successful with some subgroups. For this reason, policymakers and administrators need to know how effects vary according to the characteristics of the individual. Such information will also be necessary to make meaningful comparisons across demonstrations, to determine if there are significant selection issues for sites, and to assess the extent to which results will apply to other beneficiary populations. Therefore, as part of the process evaluation, we will conduct a participation analysis.

In a participation analysis, we will estimate binomial models (e.g., probit or logit models) of applying to the Medicare Buy-in program. In these models, the probability of participation will be a function of individual characteristics and possibly how participants learned of the demonstration. Once estimated, we will use the models to analyze the marginal effect of specific characteristics on participation, holding other characteristics constant. For instance, we would estimate the difference in participation probabilities for men and women, holding constant other demographic variables as well as program history, earnings history, and impairment.

Among the letter-targeted beneficiaries in the demonstration sites, we also will perform an analysis to characterize the differences between those most likely to participate and those less likely to participate, in a way that will be readily accessible to those not trained in the interpretation of multivariate analyses. To do this, we will first produce “predicted” participation probabilities for each case in the sample. These embody the information about characteristics of individuals that is predictive of participation, but not information about which individuals actually participated. We will then use the predictions to group cases (e.g., 75 percent or greater chance of participating, 50 – 74 percent chance, 25 – 49 percent chance, less than 25 percent chance and produce descriptive statistics for each group. Comparisons of descriptive statistics across the groups will show how those who are most likely to participate differ from those who are less likely to participate. Examining the data for each of the demonstration models could inform future targeting efforts.

### **B. Undelivered Letters Analysis**

As noted previously, the undelivered letter rate was fairly small (approximately one percent). We plan to analyze key characteristics of presumed letter recipients compared to those who had a letter returned. The analyses techniques will be similar to those outlined for the participant/non-participant analysis. We expect direct deposit beneficiaries to have a higher undelivered rate than those who have a check mailed to them because these beneficiaries who receive direct deposit have less of an incentive to update their addresses.

### **C. No-Show Rates Analysis**

During our site visits, we found that the screening model appeared to have high no-show rates for appointments at the Medicaid/welfare offices (50 to 60 percent). We consider an individual a

no-show if an appointment was made for him or her, presumably with his or her consent, and the individual subsequently canceled the appointment without rescheduling or did not show up. We want to explore this issue further by obtaining logs kept by the states in the screening and co-location sites and by the field offices in the application model sites and electronic application information available for selected states. Although this will not provide a definitive assessment of the impact of welfare stigma, office accessibility, or unfamiliarity with the Medicaid office, it will provide some indication of the potential for it if the screening sites have much higher no-show rates relative to the co-location and application sites through the process analysis. We have also explored alternative explanations for no-shows, including a lack of public transportation.

#### **D. Adjudication Analysis**

We have already calculated the percentages among those sent letters who proceed through each step of the process, up to being screened potentially eligible. With the data from the states, we will add the percent who submit an application among those referred to apply and the percent who become enrolled among those applying. Our analysis will determine whether movement through the process differs depending on the characteristics of the individuals through both cross-tabulations and regression analyses. Again, this information can inform future targeting efforts.

For some of the states, we will also have information about the reason for denial (e.g., resources exceed limits, income exceeds limits, or failed to complete process). Oklahoma and Kentucky could provide this information for all Buy-in applicants.<sup>38</sup> Florida will provide denial reason codes for QMB records. Indiana and Pennsylvania will provide this information for the demonstration site only, although Massachusetts cannot provide information about reasons for denials. Where possible, we will provide cross-tabulations of the reasons for denial by key characteristics of the applicants.

#### **E. Time Flow Analysis**

We will also analyze the average length of time and the standard deviation between each step in the process at each demonstration site—letter mailing to screening, referral to appointment and submitted application, and application to enrollment. We have already conducted some of the analyses of response time to the mailings. In addition, we will conduct hazard analyses that account for differences in the characteristics of individuals to provide information about the independent effect of these variables on the time between one step in the process and the next.

Hazard analysis is appropriate in the time flow analysis for the following reasons:

- Hazard analysis is appropriate when data correspond to the time from a well-defined time point (such as time of application) until the occurrence of some particular event (such as enrollment).
- Hazard analysis is well suited for data that are skewed or not normally distributed, and data that measures time to some event is often skewed and non-normal.

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<sup>38</sup> If we must rely on data from HCFA for Kentucky, we will have no reasons for denial.

- Measurements of time to the event of interest (such as screening time) might be censored (e.g., the event of interest might not have been observed for an individual who dropped out after the initial letter mailing because we can no longer observe his or her data). Hazard analysis takes such censoring into account.

Comparisons of time flow data may be made between sites if there is sufficient data at each site. For example, we might be interested in how the times to enrollment at one site compare with times to enrollment in another site, particularly for different states. We can test for differences between the two sets of hazard data using various methods, including the log rank test and the Wilcoxon test. In addition, through the use of hazard modeling in the analysis of time flow data, we can investigate how times to the event of interest depend on relevant individual-level explanatory variables (such as age, income level, race, etc.). Therefore, if certain individual characteristics are associated with a quicker response, potential replication or expansion efforts can benefit from this information, particularly if a site has a high concentration of individuals who are likely to respond more quickly or more slowly.

## **IV. FINAL REPORT**

### **A. Impact Analysis**

*Exhibit 8.2* summarizes the key components of the impact analyses. We will conduct a combined pre-post and comparison group non-experimental design for the outcome evaluation relying on the difference between the change in enrollment from the pre-to-post periods for the demonstration sites and the comparison areas. This approach is called a difference in difference (DID) analysis.

Based on our site visits, we have concluded that despite some variations by site, the demonstration models appear to have been implemented consistently enough in terms of the core aspects that the effects of each demonstration model on the outcomes can be assessed jointly across sites for each model and also independently, sample sizes permitting.<sup>39</sup> Further analysis might cause us to revisit this assessment. The advantage to evaluating multiple sites jointly is that pooling the data across sites increases sample sizes and contributes to more precise estimates of program and other effects. The one aspect that potentially poses a problem for combining across sites is the use of self-declaration rather than verification in Texas, Pennsylvania, and the demonstration sites in Florida. We expect self-declaration would result in higher approval rates than verification. This is a particular concern in Florida where the same practices were not carried out statewide. For these sites, it could be difficult to determine how much of the impact on enrollment is the result of the demonstration outreach or model versus the use of self-declaration in the demonstration sites and not the rest of the state.

We view the outcome and process evaluations as complementary activities. The outcome evaluation will use information from the process evaluation both to refine the quantitative methodology and interpret the findings. The outcome evaluation will also provide quantitative answers to questions that the process evaluation might only answer in a qualitative fashion.

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<sup>39</sup> The widow(er)s demonstration will not permit independent evaluations of the demonstration sites because of inadequate sample sizes.



**Exhibit 8.2****Key Aspects of the Pre-Post Impact Analyses**

Study Population
<ul style="list-style-type: none"> <li>• Letter targeted</li> </ul>
Outcome Measures
<ul style="list-style-type: none"> <li>• Applicants (not available for all states for comparison groups)</li> <li>• Enrollees</li> </ul>
Analysis Groups
<ul style="list-style-type: none"> <li>• Pre-period demonstration site</li> <li>• Post-period demonstration site</li> <li>• Pre-period comparison site</li> <li>• Post-period comparison site</li> </ul>
Likely Explanatory Variables
<ul style="list-style-type: none"> <li>• Age</li> <li>• Sex</li> <li>• Race</li> <li>• Language preference (as a proxy for Hispanic)</li> <li>• Social Security benefit as a percentage of the poverty level</li> </ul>
Time Period for Analyses
<ul style="list-style-type: none"> <li>• March 1998-December 1998 (Oklahoma will differ) for pre-period analysis</li> <li>• March 1999-December 1999 (Oklahoma will differ) for post-period analysis</li> <li>• Three months following last letter mailings for each model (post-period)</li> <li>• Same three months in pre-period</li> </ul>

**1. Study Populations**

For the analyses, we will examine those targeted for letters (Medicare beneficiaries not currently receiving Buy-in benefits and having Title II income less than 135 percent of the poverty guideline) living within the demonstration as well as their counterparts in the comparison site. We considered conducting an analysis based on all Medicare beneficiaries not receiving Buy-in benefits to account for those responding to solicitations that do not receive a letter. However, of those individuals screened who did not indicate that they heard about the program through a letter (14.8 percent), 62 percent match to the MBR letter file. Therefore, approximately only five percent of those screened might not have received a letter.

For the widow(er)s model, we will need to identify recent widows in the pre- and post-periods based on the MBR data. We will accomplish this using variables related to the beneficiary identification code (BIC), type of claim, date of death of primary, and the date of entitlement change. The exact specifications will be developed in conjunction with SSA.

**2. Comparison Sites**

Using the DID approach, the remainder of the state can be used as a comparison site, on the assumption that assessing the *increase* in enrollment accounts for other factors not explicitly modeled. We also identified comparison sites that are in the same state and have similar economic and demographic characteristics to the demonstration site. By examining both of these comparisons (the rest of the state and selected comparison sites), we can determine whether the chosen comparison site makes a difference in the analysis.

We have tabulated economic and demographic characteristics by county (or city) for each state in the demonstration (Florida, Indiana, Kentucky, Oklahoma, Pennsylvania, and Texas). For Florida and Oklahoma, tabulations are by city. We chose to tabulate by county in states where zip codes included in the demonstration project corresponded to a county. Likewise, we chose to tabulate by city in states where demonstration zip codes corresponded to a city. We used the 1990 Decennial Census for our tabulations. Information about Medicare came from the HCFA.

For each county (or city) in a demonstration state, we have information on the following:

- Metropolitan Statistical Area (MSA) status
- Total population
- Population over age 65
- Population over age 85
- Percentage of Medicare enrolled in Medicare + Choice in 1998
- 1997 Medicare + Choice Adjusted Average Per Capita Cost (AAPCC) rate<sup>40</sup>
- Percentage with no high school diploma
- Percentage with college degree
- Median income

For the population over age 65, we also have information on the following:

- Percent black
- Percent Hispanic
- Percent female
- Percent living alone
- Percentage with no telephone
- Percentage with no vehicle
- Percentage with self-care limitation
- Percentage in poverty
- Percentage with own home

All of the demonstration sites are part of a Metropolitan Statistical Area (MSA) (i.e., urban areas). Because urban areas are different from rural areas, urban areas were chosen as comparison sites. For Florida and Oklahoma, where we chose to tabulate by city, we used total population in a city as a matching criterion. We sorted our counties and cities by percentage in

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<sup>40</sup> We decided to use the 1997 Adjusted Average Per Capita Cost (AAPCC) rate, because in 1998 HCFA changed the way AAPCC is calculated. The change no longer links the AAPCC directly to a county's Medicare costs. As a result, the earlier AAPCC rate is a better indicator of average health care cost by area. For Florida and Oklahoma, we present the AAPCC rate for the counties that make up the areas in the demonstration.

poverty and population over age 65. We matched comparison sites to demonstration sites on the basis of poverty and elderly population. We also made sure that the racial composition of the demonstration and comparison sites is similar. We refrained from pairing a predominantly black county and a predominantly white county, for example. We also attempted to choose comparison sites with similar numbers of people or percentages of the population age 65 and over. Three issues of note:

- Meeting all of these criteria for the Miami, Florida demonstration site was difficult because the city has a large Hispanic population. We wanted to choose a comparison site with a similar ethnic racial composition because we think Hispanic populations might have higher response rates. Other cities in Florida with large Hispanic populations are also in Dade County; therefore, we were forced to choose Hialeah City, which is also in Dade County, as our comparison site.
- We initially chose Tulsa, Oklahoma, as the comparison area for Oklahoma City. However, we reconsidered this choice when we verified that Tulsa has had a co-located worker since April 1999 spending about 20 hours at the field office each week. This makes Tulsa a less than ideal comparison site because it is operating in a manner similar to the demonstration. As a result, Lawton was chosen as the comparison site.
- In Indiana, the two other counties that have piloted the short form along with Vanderburgh County (Clay County and Saint Joseph County) might also need to be treated separately.

**Exhibit 8.3** provides a list of demonstration and comparison sites. **Exhibit 8.4** and **Exhibit 8.5** provide economic and demographic characteristics. The variables in **Exhibit 8.4** refer to the entire population, although those in **Exhibit 8.5** refer only to the population over age 65. **Exhibit 8.6** delineates population change by age group between 1990 and 1998.

The request for proposal (RFP) indicated that SSA would choose a comparison area for the widow(er)s model. The premise that there would be a comparison area was established before the demonstration's going statewide. Given the differences in state policies for Buy-in outreach and enrollment, it would be difficult to choose another state as a comparison area. Therefore, our analysis plan calls for just a pre-post comparison. However, as we discuss later in this chapter, given the evolution of this model and the general lack of response, this approach also faces some difficulties.

**Exhibit 8.3****Demonstration and Comparison Sites**

<b>Demonstration Site</b>	<b>Corresponding Comparison Site</b>
FL, Orlando	FL, West Palm Beach
FL Miami	FL, Hialeah City
IN, Vanderburgh County	IN, Delaware County
KY, Fayette County	KY, Jefferson County
OK, Oklahoma City	OK, Lawton City
OK, Muskogee City	OK, Guthrie City OK, Chickasha City OK, Altus City
PA, Chester County	PA, Delaware County
PA, Cumberland County	PA, Bucks County
PA, Lebanon County	PA, Monroe County
PA, Perry County	PA, Columbia County
PA, Fayette County	PA, Somerset County
TX, Nueces County	TX, San Patricio County

**3. Outcome Measures**

We will use two outcome measures—application and successful enrollment—as a measure of demonstration success. For all but the widow(er)s model, successful enrollment is available for the demonstration and comparison sites in the pre- and post-periods. Applicants will be defined as those who file an application with the state Medicaid agency. Applicants can be considered a measure of the success of the outreach efforts, and successful enrollment as the bottom-line measure of the success of the demonstration. Successful applicants, or enrollees, will be defined as those who are eligible for Medicare Buy-in benefits. Applicant information will not be available for most states because this information is not retained on their MIS. Only Oklahoma and Pennsylvania data will permit analysis of applicant data for the pre- and post-periods in both demonstration and comparison sites. We will also conduct separate analyses for QMBs, SLMBs, and QI-1s to determine whether there are fundamental differences among the enrollment and successful enrollment for these three groups by individual characteristics. These analyses will likely require pooling data across sites to provide enrollment information for the pre and post-period that can be matched to widow(er)s on the MBR dates, Third Party Master File.

In Massachusetts, unless we can obtain HCFA data, our outcome measure will not have a consistent variable for enrollment available for the pre- and post-periods. We expect that, even with the HCFA data, we might have difficulty distinguishing whether Buy-in enrollees are QMB, SLMB, or QI-1.

### Exhibit 8.4

#### Economic and Demographic Characteristics

AREA NAME	Population					% Mcare +Choice	AAPCC Part AB	% No HS	% College	Median Income
	Total	65+	%65+	85+	%85+					
Florida										
Miami City*	358,548	59,931	17	6,046	1.7	45.08	748	52.4	17.7	\$16,925
Hialeah City	188,004	26,188	14	2,412	1.3	45.08	748	53.8	12.8	\$23,443
Orlando City*	164,693	18,717	11	2,085	1.3	39.47	528	21.9	29.8	\$26,119
West Palm Beach City	67,643	12,359	18	1,406	2.1	36.32	566	28.3	27.2	\$26,504
Remainder of State	12,414,685	2,289,995	18	197,455	1.6	25.01	507	24.9	25.1	
Indiana										
Vanderburgh County*	165,058	25,904	16	2,782	1.7	10.96	393	24.8	21.8	\$25,798
Delaware County	119,659	15,114	13	1,431	1.2	0.10	401	25.5	21.2	\$24,436
Remainder of State	5,379,101	670,041	12	66,720	1.2	3.64	415	24.3	20.9	
Kentucky										
Fayette County*	225,366	22,303	10	1,955	0.9	4.12	363	19.8	36.4	\$28,056
Jefferson County	664,937	89,367	13	8,807	1.3	11.20	465	25.9	24.6	\$27,092
Remainder of State	3,598,107	445,624	13	43,089	1.2	5.80	422	35.6	17.6	
Oklahoma										
Muskogee City*	37,708	7,061	19	736	2.0	4.51	377	31.1	21.3	\$19,507
Altus City	21,920	2,509	11	260	1.2	3.58	488	24.6	24.9	\$22,098
Chickasha City	14,988	2,876	19	374	2.5	4.04	327	33.5	20.1	\$18,537
Guthrie City	10,518	2,022	19	380	3.6	14.76	436	35.2	15.0	\$20,491
Muskogee Comp Site	15,805	2,469	16	338	2.1	13.67	430	29.8	21.2	
Oklahoma City*	444,730	52,591	12	5,011	1.1	14.76	436	21.8	26.4	\$25,741
Lawton City	80,561	7,345	9	689	0.9	8.49	384	18.5	24.3	\$24,200
Remainder of State	2,663,147	363,942	14	38,201	1.4	9.05	425	25.8	22.3	
Pennsylvania										
Chester County*	376,396	40,769	11	3,748	1.0	32.71	512	15.1	40.6	\$45,642
Montgomery County	678,111	101,976	15	10,540	1.6	38.74	516	16.2	38.0	\$43,720
Cumberland County*	195,257	26,128	13	2,558	1.3	13.08	403	19.0	29.0	\$34,493
Bucks County	541,174	58,784	11	5,456	1.0	41.05	576	17.1	31.6	\$43,347
Fayette County*	145,351	26,169	18	2,300	1.6	23.14	583	32.2	12.9	\$19,195
Somerset County	78,218	13,252	17	1,061	1.4	33.04	487	31.1	12.5	\$21,674
Lebanon County*	113,744	16,749	15	1,608	1.4	14.75	370	30.0	15.6	\$29,469
Monroe County	95,709	12,514	13	950	1.0	12.37	504	22.0	22.7	\$32,465
Perry County*	41,172	4,569	11	357	0.9	10.05	475	27.7	13.5	\$29,539
Columbia County	63,202	9,974	16	953	1.5	35.04	429	26.9	16.9	\$24,211
Remainder of State	11,204,980	1,741,455	16	160,026	1.4	27.36	526	25.6	22.8	
Texas										
Nueces County*	291,145	29,063	10	2,247	0.8	29.48	486	31.1	23.0	\$25,337
San Patricio County	58,749	6,013	10	485	0.8	29.71	468	39.4	15.9	\$22,864
Remainder of State	16,695,365	1,679,195	10	159,788	1.0	17.00	469	28.0	25.5	
U.S. Total	248,709,873	31,195,275	13	3,003,328	1.2	17.59		24.8	26.5	\$30,056

Source: The Lewin Group tabulations of 1990 Decennial Census, 1998 HCFA Medicare+Choice enrollment data, and 1997 HCFA AAPCC rates.

Note: \* Indicates demonstration site.

## Exhibit 8.5

## Economic and Demographic Characteristics, Population Age 65+ (Percent)

AREA NAME	In Poverty	Black	Hispanic	Female	Live Alone	With Limit	Own Home	No Vehicle	No Phone
Florida									
Miami*	32.2	11.9	73.1	60.9	27.3	27.4	40.5	45.7	4.9
Hialeah City	24.5	1.0	86.5	59.2	14.8	25.3	53.1	30.1	1.4
Orlando*	16.1	16.7	5.3	62.6	34.1	20.6	65.3	26.3	3.5
West Palm Beach	15.6	15.7	9.2	61.6	36.2	20.0	68.3	25.8	3.7
<b>Remainder of State</b>	<b>10.2</b>	<b>5.2</b>	<b>5.5</b>	<b>57.4</b>	<b>26.3</b>	<b>17.8</b>	<b>83.1</b>	<b>16.0</b>	<b>2.1</b>
Indiana									
Vanderburgh County*	11.6	5.3	0.2	63.2	35.9	21.4	74.7	23.4	1.8
Delaware County	12.1	5.5	0.1	62.4	35.7	19.4	81.7	18.9	2.3
<b>Remainder of State</b>	<b>10.7</b>	<b>5.5</b>	<b>0.1</b>	<b>60.6</b>	<b>32.5</b>	<b>19.6</b>	<b>78.5</b>	<b>18.7</b>	<b>2.4</b>
Kentucky									
Fayette County*	13.2	12.5	0.3	62.7	32.7	21.3	69.9	24.3	2.2
Jefferson County	12.2	12.6	0.3	62.7	33.3	22.1	75.4	25.9	2.2
<b>Remainder of State</b>	<b>20.5</b>	<b>5.9</b>	<b>0.2</b>	<b>60.3</b>	<b>32.7</b>	<b>24.6</b>	<b>77.7</b>	<b>23.7</b>	<b>5.3</b>
Oklahoma									
Muskogee City*	18.2	15.2	0.2	62.1	39.0	21.7	72.8	21.5	4.0
Altus City	18.5	6.8	3.2	63.3	36.7	24.9	80.0	19.6	3.1
Chickasha City	17.8	6.2	0.8	64.4	35.5	29.7	81.8	18.4	5.0
Guthrie City	19.2	12.5	1.1	65.6	41.4	17.9	78.9	16.8	3.8
Muskogee Comp Site	18.4	8.1	1.7	64.4	37.5	22.6	81.0	17.7	4.1
Oklahoma City*	13.1	10.8	1.1	61.7	35.0	20.7	78.2	17.0	2.4
Lawton City	13.2	9.1	2.5	61.3	32.0	13.5	87.9	8.5	3.8
<b>Remainder of State</b>	<b>18.6</b>	<b>3.7</b>	<b>0.6</b>	<b>59.7</b>	<b>33.4</b>	<b>21.7</b>	<b>83.5</b>	<b>15.8</b>	<b>4.0</b>
Pennsylvania									
Chester County*	6.1	5.6	0.6	58.8	24.9	16.1	76.2	16.6	0.8
Montgomery County	5.8	3.4	0.4	60.9	27.8	16.5	73.0	18.3	0.7
Cumberland County*	6.0	0.7	0.3	60.4	29.8	14.3	77.1	15.0	0.7
Bucks County	6.1	1.4	0.4	59.1	25.6	17.5	76.5	17.3	0.6
Fayette County*	14.5	3.6	0.2	60.1	32.4	24.5	79.9	26.3	2.2
Somerset County	13.6	0.0	0.1	59.3	31.6	22.4	83.1	21.4	2.9
Lebanon County*	8.7	0.2	0.2	60.3	32.0	16.1	73.6	22.2	2.1
Monroe County	8.9	0.9	0.8	56.3	23.7	14.0	82.4	14.2	1.4
Perry County*	11.2	0.0	0.2	57.4	28.1	18.3	82.2	19.4	2.4
Columbia County	10.2	0.1	0.1	60.4	32.1	19.2	79.6	17.9	0.8
<b>Remainder of State</b>	<b>10.6</b>	<b>6.4</b>	<b>0.5</b>	<b>60.8</b>	<b>31.3</b>	<b>20.2</b>	<b>75.9</b>	<b>27.7</b>	<b>1.5</b>
Texas									
Nueces County*	20.2	5.0	36.0	59.0	29.4	22.9	74.5	18.8	4.6
San Patricio County	21.4	1.4	34.5	56.8	23.5	28.5	84.4	16.6	7.3
<b>Remainder of State</b>	<b>18.3</b>	<b>9.2</b>	<b>12.3</b>	<b>59.7</b>	<b>29.9</b>	<b>21.5</b>	<b>79.8</b>	<b>17.0</b>	<b>4.1</b>
U.S. Total	<b>12.8</b>	<b>8.0</b>	<b>3.4</b>	<b>59.9</b>	<b>30.5</b>	<b>20.1</b>	<b>75.0</b>	<b>22.3</b>	<b>2.5</b>

Source: The Lewin Group tabulations of the 1990 Decennial Census.

Note: \* Indicates demonstration site.

### Exhibit 8.6

#### Population Change, 1990–1998

AREA NAME	1990 Population			1998 Population			% Change		
	Total	65+	85+	Total	65+	85+	Total	65+	85+
Florida	13,712,052	2,368,643	205,586	14,915,980	2,534,982	248,368	8.8	7.0	20.8
Miami*	358,648	59,931	6,046	368,624			2.8		
Hialeah City	188,004	26,188	2,416	211,392			12.4		
Orlando*	164,674	18,717	2,085	181,175			10.0		
West Palm Beach	67,764	12,359	1,406	76,308			12.6		
Indiana	5,544,156	695,945	69,502	5,899,195	739,584	87,965	6.4	6.3	26.6
Vanderburgh County*	165,058	25,904	2,782	168,179	26,329	3,257	1.9	1.6	17.1
Delaware County	119,659	15,114	1,431	116,828	15,721	1,786	-2.4	4.0	24.8
Kentucky	3,686,892	466,816	44,064	3,936,499	492,855	57,065	6.8	5.6	29.5
Fayette County*	225,366	22,303	1,955	241,749	24,938	3,000	7.3	11.8	53.5
Jefferson County	665,123	89,367	8,807	672,104	93,979	11,091	1.0	5.2	25.9
Oklahoma	3,229,393	423,594	43,948	3,346,713	448,388	56,543	3.6	5.9	28.7
Muskogee*	37,708	7,061	736	38,386			1.8		
Altus City	21,910	2,509	260	21,552			-1.6		
Chickasha City	14,988	2,876	374	16,180			8.0		
Guthrie City	10,440	2,022	380	10,281			-1.5		
Muskogee Comp Site	15,805	2,469	338	16,004			1.3		
Oklahoma City*	444,724	52,591	5,011	472,221			6.2		
Lawton City	80,561	7,345	689	81,107			0.7		
Pennsylvania	11,882,842	1,829,711	168,039	12,001,451	1,904,313	221,422	1.0	4.1	31.8
Chester County*	376,396	40,769	3,748	421,686	49,118	5,507	12.0	20.5	46.9
Montgomery County	678,193	101,976	10,540	719,718	118,192	15,027	6.1	15.9	42.6
Cumberland County*	195,257	26,128	2,558	208,634	31,175	3,892	6.9	19.3	52.2
Bucks County	541,174	58,784	5,456	587,942	73,224	8,402	8.6	24.6	54.0
Fayette County*	145,351	26,169	2,300	144,847	23,749	2,895	-0.3	-9.2	25.9
Somerset County	78,218	13,252	1,061	80,267	14,371	1,595	2.6	8.4	50.3
Lebanon County*	113,744	16,749	1,608	117,434	19,417	2,294	3.2	15.9	42.7
Monroe County	95,709	12,514	950	125,583	15,678	1,623	31.2	25.3	70.8
Perry County*	41,172	4,569	357	44,384	5,270	559	7.8	15.3	56.6
Columbia County	63,202	9,974	953	64,120	10,369	1,198	1.5	4.0	25.7
Texas	16,986,335	1,708,258	162,035	19,759,614	1,999,751	226,591	16.3	17.1	39.8
Nueces County*	291,145	29,063	2,247	316,340	33,519	3,384	8.7	15.3	50.6
San Patricio County	58,749	6,013	485	71,393	6,927	752	21.5	15.2	55.1
<b>U.S. Total</b>	<b>248,709,873</b>	<b>31,195,275</b>	<b>3,003,328</b>	<b>270,299,000</b>	<b>34,401,000</b>	<b>4,054,000</b>	<b>8.7</b>	<b>10.3</b>	<b>35.0</b>

Source: The Lewin Group tabulations of Census population data.

Notes: \* Indicates demonstration site. City population by age group is unavailable.

## **4. Analyses**

As noted in the previous sections, we have or will soon have individual data for both demonstration and comparison groups in both the pre- and post-periods for all states, with the exception of Massachusetts. (We address our analysis plan for Massachusetts in Section IV.D.1.) These data will allow us to identify those already enrolled in the Buy-in program and those who meet the other criteria for letter receipt as well as other characteristics that can be found in the MBR. The availability of this information for the comparison group in both the pre- and post-periods as well as for the pre-period demonstration group allows us to effectively deal with the selectivity issue (i.e., by using a DID approach, we control for bias generated by the sites included in the demonstration versus the comparison sites).

For the pre-post analyses, we will use predicted aggregate percentages for the percent applying and the percent successfully enrolled on a monthly basis for those who were targeted for a letter. These individuals will have to be defined at a point in time. The first wave of letters was sent in March 1999. Hence, we have defined the samples on the basis of reported beneficiary status as of the end of March 1999 for the post-period samples and as of March 1998 for the pre-period samples. We wish to have data for the same months for the post- and pre-periods. This will permit us to focus on information through the three months following letter solicitations for each model and also to analyze the full time period if necessary. We will have about one year of historical data for all states except Massachusetts.<sup>41</sup> We have requested data from Oklahoma starting in October 1997 to capture the one-year period before a co-located worker was stationed in the Oklahoma City and Muskogee field offices. Texas will send monthly data that span the previous three years.

We expect to observe the greatest impact in the middle months of the demonstration because the greatest response to the call center occurred shortly after the mailings and because the application approval process will likely take one to two months. For the post-period demonstration group, we will include individuals whose letters are returned because we cannot exclude corresponding cases from the other groups. This should not introduce bias because the returned letter rate was less than one percent.

It is important to note that the pre- and post-groups of each site (demonstration or comparison) are not the same people. Although many beneficiaries will be in the sample in both periods, we will treat them as independent groups. If, instead, we followed individuals for two periods, we would encounter an attrition problem. The fact that the pre- and post-samples are not entirely independent has some implications for statistical precision, which we will return to at the end of this section.

For Buy-in enrollment among the letter-targeted groups, we will calculate “adjusted percent enrolled” for each of four groups: pre- and post-demonstration and pre- and post-comparison on a monthly basis beginning in March of the relevant year. We tentatively plan to make the adjustment for each group *in each month* as follows:

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<sup>41</sup>For Indiana, we will have 11 months of pre-demonstration data.



1. We will run a regression (linear probability model) of enrollment on a small set of explanatory variables from the MBR (e.g., monthly Title II income as a percentage of the poverty guideline, age, sex, and language preference). A separate regression will be run for each of the four groups in each month. For the post-period demonstration group, we will also include a dummy variable for when the letter was sent. The samples for each demonstration model will be large—between 28,000 in the screening model and nearly 110,000 in the application model—so regression coefficients should be precise. In the first few months, however, enrollment might be so low that we will not be able to estimate the models. When the comparison group is the entire rest of the state, we will also introduce explanatory variables related to county and city characteristics that might be expected to affect the change in enrollment over time. These include 1) the percentage of the population age 65 and over with income below the poverty level, because higher levels might indicate a more active outreach program, and 2) the percentage of persons age 65 and older who live alone, do not own a car, and have limitations in personal care, because these might indicate difficulty in keeping an appointment.
2. We will use the regression model to predict the probability of enrollment for a person with the mean characteristics of the post-period demonstration sample. For the post-period demonstration group, this will be identical to the actual percent enrolled. For the other groups, this will deviate from the actual percent enrolled by an amount that is an adjustment for the differences between the mean characteristics of those in that group and those in the post-period demonstration group.

For each month, the DID impact estimate will be the pre-post change in the adjusted percent enrolled for the demonstration group minus the pre-post change in the adjusted percent enrolled for the comparison group. Given the fluctuations in the number of letters mailed over time, this difference is expected to vary for the different months (see *Exhibit 8.7*). QMB, SLMB, and QI-1 enrollments will be combined for this analysis. However, we expect that the coefficient for Social Security income as a percentage of the poverty guideline would differ for the three groups. To determine whether there are fundamental differences among the enrollment for these three groups by individual characteristics, we will conduct separate analyses for QMBs, SLMBs, and QI-1s using data pooled across months to achieve sufficient sample size.

To pool across months, we must convert the analysis to a hazard analysis. For each individual, there will be one observation for each month up to the month in which he or she enrolled. The “discrete-time linear hazard model” will simply extend the regression model to include dummy variables for the month. Depending on the results/explanatory power, we also will consider a more sophisticated hazard model, such as the discrete logistic hazard model, which would be analogous to replacing the linear probability model with logit. If a hazard model is estimated for each of the four groups by program type, it will be used to predict enrollment probabilities in each month for a person with specified characteristics. The probabilities from the four groups will then be used to compute the DID estimates. We could, of course, also pool the various samples for the hazard analysis if the data do not permit separate analyses for each group.

We could also pool the four groups (pre- and post-periods, comparison, and demonstration) samples for estimating the regression models, and we might be forced to do so if successful enrollment rates in the first few months are too low. The specification would be the same,

except that we would include a separate intercept for each of the four groups. The DID estimator would then become the pre-post change in the demonstration group intercept minus the change in the comparison group intercept.

We could also partially pool the data, in a variety of ways. For instance, we could pool both pre-period groups and the post-period comparison group, with a separate regression model for the post-period demonstration group alone. This might be sufficient to address the issue of limited enrollments in these groups. We can also test whether the restrictions implied by pooling the data are correct. Another option would be to pool all the samples but allow, explicitly, for interactions between selected explanatory variables and the group dummies. We could also pool across sites, again testing the implicit restrictions. As a practical matter, we prefer to examine descriptive statistics for the four groups first, then use pooling as needed to address sample size or enrollment issues.

The sample sizes appear to support the separate analysis. This is preferable to pooling because the pooled analysis imposes the constraint that the intervention's impact on the probability of enrollment does not depend on the individual's characteristics (i.e., that it causes a parallel shift in the regression function for the demonstration group). We think this is incorrect, especially with respect to Social Security payment levels because those with high payments are less likely to meet the Buy-in criteria than are those with low payments. With separate equations, we can allow the effects to be different. Further, we can use the regression equations to estimate impacts for individuals other than the hypothetical beneficiary with the mean characteristics of the post-period demonstration group. For instance, we could estimate effects for those with Social Security benefits at 50, 75, and 125 percent of the poverty guideline. We think this information could be valuable to SSA for future letter-writing efforts.

As indicated earlier, we will conduct our analyses compared to the rest of the state and to the selected comparison sites. If we have sufficient enrollment, we will conduct some analyses at the site level. When we conduct the analyses pooled across sites, we will weight the demonstration site relative to the rest of the state or the selected comparison areas consistently across states. We will accomplish this by weighting the number of individuals in the comparison areas so they equal the number of individuals in the demonstration sites in each state. For example, if there are 10,000 letters mailed in a demonstration site and 20,000 individuals meeting the same criteria in the comparison area, we will apply a weight of 0.5 to the comparison area in that state.

**Exhibit 8.7****Mailings, Screenings, and Screened Eligible by Demonstration Model**

		March 99	April 99	May 99	June 99	July 99	August 99	Sept 99	Oct 99	Nov 99	Dec 99	Total
Screening	Mailings	8,164	13,632	5,470	895	0	0	0	0	0	0	28,161
	Screenings	380	582	337	111	16	12	12	5	6	3	1,464
	Screened Eligible	162	253	160	66	8	8	6	1	1	2	667
Co-location	Mailings	0	32,850	16,379	19,405	17,313	0	0	0	0	0	85,947
	Screenings	0	1,191	994	891	760	299	114	42	19	14	4,324
	Screened Eligible	0	642	580	581	500	226	87	34	16	12	2,678
Application	Mailings	0	24,302	24,002	26,889	24,832	24,977	0	0	0	0	125,002
	Screenings	1	955	2,260	1,908	1,641	1,756	381	175	144	87	9,308
	Screened Eligible	1	549	1,350	1,168	1,083	1,176	280	127	110	58	5,902
Total	Mailings	8,164	70,784	45,851	47,189	42,145	24,977	0	0	0	0	239,110
	Screenings	381	2,728	3,591	2,910	2,417	2,067	507	222	169	104	15,096
	Screened Eligible	163	1,444	2,090	1,815	1,591	1,410	373	162	127	72	9,247

Source: The Lewin Group interviews with SSA central office staff and The Lewin Group tabulations of screening data.

## **5. Variations by State and Site**

*Exhibits 3.1 and 6.1*, in previous chapters, highlight issues specific to each state that could influence our results or need to be accounted for in our analyses.

### *(a) Outreach*

None of the state Medicaid agencies reported increasing their outreach efforts after the start of the demonstration. Staff from the state agencies sometimes gave presentations to senior citizens' groups, set up booths at fairs, and sent flyers to local offices, although these were not new efforts. Massachusetts reported that the SHINE (Serving Health Information Needs of Elders) program conducted extensive outreach efforts throughout the state during 1999. In Massachusetts, we will not have a comparison group to control for outreach independent of the demonstration; therefore, some of the observed impact from the pre- to post-period could have occurred because of other outreach activities.

An outreach effort conducted by HCFA in Texas could affect findings from the Buy-in demonstration. In December 1998 and January 2000, HCFA sent more than 60,000 notices to potential eligibles who had enrolled in Part A in October 1998 and who had Title II income less than 100 percent of the federal poverty level. The letters included information about the Buy-in program and asked interested beneficiaries to return a postcard to the Texas Department of Human Services. The Texas office then mailed the short applications to those who expressed an interest. The extent to which this effort will dilute the impacts of the Buy-in demonstration depends on how many individuals enrolled in the rest of the state who would not have enrolled otherwise. As of March 12, 1999, 4,910 post cards had been returned. We expect that any effect as a result of HCFA's outreach effort would be similar for our demonstration site and our comparison areas in Texas. Recipients of HCFA's Texas mailing were excluded from SSA's mailing.

### *(b) Application Procedures*

As noted in Chapter 6, the application procedures vary among the states in terms of length of application, process for verifying application information, and program categories covered by the application. Also, some states require face-to-face interviews although other states accept applications mailed to the office. Below is a description of the application procedures for each state.

- Both Florida and Kentucky developed two-page applications to be completed at the SSA offices in the demonstration areas. Outside the demonstration areas, Florida uses a one-page preliminary application followed by a face-to-face interview and an online application (i.e., not paper). Florida is also using self-declaration at the demonstration sites only. This might result in a higher successful enrollment rate relative to the comparison sites as a result of the different process in addition to the outreach effort. Kentucky also uses an online application outside Fayette County, which we would not expect to influence the impact analysis.
- Indiana piloted a two-page QMB application in two counties, St. Joseph and Clay, and has begun using this application in Vanderburgh County. The state began to use this shorter

application in all counties in September. Individuals can use this application to get full coverage, although they must request these additional benefits. This means our analysis for the April-to-September period cannot control for the possible effects of the use of a short form, unless we use St. Joseph or Clay County as the comparison area.

- Pennsylvania began using a shortened application form for the Buy-in program statewide in June 1999. This application can be submitted by mail or in person. Redetermination cannot be conducted by mail. In conducting our analyses in Pennsylvania, we will pay particular attention to shifts in successful enrollment rates in the comparison areas following the introduction of the short-form application.
- We discuss the implications of the anomalies in the Massachusetts application procedures in a later section.

### *(c) Subanalyses*

The information from the states also suggests that there might be some “natural” experiments across some of the sites that lend themselves to analyses:

**Short form versus long form.** All four application model states are using Buy-in applications that are shorter than a full Medicaid application. Florida and Kentucky are using them in the demonstration site only. Texas has used statewide since last year a short form and self-declaration for the application. Indiana is piloting the shorter application in the demonstration site and two other counties and will go statewide in September; Pennsylvania went statewide midway through the demonstration with a shorter application. In Pennsylvania, we can examine the impact before and after the introduction of the short form to see if the short form appears to have an independent effect. For the co-location models, it might also be possible to compare Pennsylvania and Oklahoma for a short form versus long form effect. We would like to examine effects in Texas versus the other sites, but it will probably be impossible to distinguish whether observed differences are related to the short form or to the self-declaration policy or other aspects of the state’s implementation.

**Co-located model with direct mailing versus without direct mailing.** The early implementation of a co-located worker in the Oklahoma sites permits us to examine the increase in enrollment (relative to the comparison sites) because of the co-location of a state worker in the office from October 1998 to before the start of the direct mailings in April 1999. Comparing the effect during this period to the effect after the start of the demonstration will provide information about the independent effect of a co-located worker without direct mailings.

### *(d) Massachusetts*

Conducting an impact analysis for Massachusetts poses a challenge given we will not get pre-demonstration data or demonstration period data for enrollees who were not SSA screened (unless we can get data from HCFA) and because we do not have a comparison site for the state. In addition, the participation rate has been low relative to the other sites. As of December 30, 1999, only 560 were screened, of which 217 were determined to be potentially eligible. Only about half of these potential eligibles have been tracked by the state, resulting in 23 enrollments.

The analysis plan for the widow(er)s model is to conduct a pre-post analysis. Using MBR data, we will identify widow(er)s in the pre and post period. The MBR data will be matched to HCFA Buy-in data to calculate monthly Buy-in enrollment rates in the pre- and post-periods. We will then conduct econometric analyses to determine if the percentage of widow(er)s during the demonstration is different than in the previous year. We will also examine the percentage of this subset who SSA screened during the demonstration. This analysis lacks the advantage of the DID approach because it fails to control for changes that would have occurred in the absence of the demonstration. The analysis is further complicated by the introduction of the short form for premiums only at about the same time as the start of the demonstration. We are also exploring the possibility of using aggregate data on non-demonstration enrollment on a monthly basis as a potential comparison. This approach will not allow individual-level characteristics to be held constant but could provide rough measures of the potential impact of the demonstration.

## **6. Estimation Precision and Sensitivity**

We have assessed the minimum impact that can be detected by the DID estimator with an 80 percent chance (i.e., probability of a Type II error is 20 percent) using a significance level of five percent (i.e., probability of a Type I error is 5 percent). To make the problem tractable, we first consider a different scenario in which the DID estimator is applied to unadjusted demonstration and comparison group percentages and independent pre- and post-samples of equal size,  $n$ . shows how the minimum detectable impact, measured as a change in percent, varies with  $n$ .<sup>42</sup>

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<sup>42</sup> The DID estimator is a difference in percent minus an independent difference in percent. The variance for a percent from a simple random sample can be no larger than  $.25/n$ ; the variance of a difference in percent for two independent samples can be no larger than twice that amount,  $.5/n$ ; and the variance of the difference in differences for two independent differences in percent can be no larger than twice that amount,  $1/n$ . Hence, under the simplified scenario the standard error for the DID estimator can be no larger than the square root of this value,  $n^{-.5}$ . Assuming that the sample size is large enough to apply the central limit theorem, the minimum detectable impact for an estimator is  $\mu = (z_\alpha + z_\beta)SE_{\max}$ , where  $z_c$  is the value that cuts off an area of  $c$  percent in the tail of a standard normal distribution,  $\alpha$  and  $\beta$  are the probabilities of Type I and Type II error, respectively, and  $SE_{\max}$  is the maximum standard error. Application of the central limit theorem in this case seems reasonable, unless the impact is so small that, for policy purposes, it is of little interest.

**Exhibit 8.8****Minimum Detectable Impacts for DID Estimators, by Demonstration Model<sup>a</sup>**

<b>Model</b>	<b>Number of Letters Mailed</b>	<b>Minimum Detectable Difference</b>
Screening	28,161	1.4
Carlisle, PA	15,416	1.5
Lebanon, PA	12,745	1.7
Co-location	85,255	0.4
Oklahoma City, OK	17,124	1.4
Muskogee, OK	34,757	0.9
West Chester, PA	11,357	1.7
Uniontown, PA	22,709	1.2
Application	119,813	0.1
Lexington, KY	15,764	1.4
Evansville, IN	15,819	1.4
Corpus Christi, TX	18,611	1.3
Miami, FL	8,356	2.1
Orlando, FL	66,452	0.4

Source: SSA provided mailing information and The Lewin Group calculations.

<sup>a/</sup> Assumes independent pre- and post-samples of size n for both the demonstration and comparison groups. Minimum detectable differences are percentage points.

SSA will need to determine the size of the acceptable minimum detectable impact. However, the size of the mailings, even at the site level, produce low minimum detectable differences. Further, as we will discuss below, the assumption of independence for the pre- and post-period samples results in conservative estimates.

The adjustments we propose to control for population characteristics among the different analysis groups (the pre/post and demonstration/comparison combinations) will have little impact on the minimum detectable size because the variance of each of the adjusted percents will likely be just a little larger than the variance of the unadjusted percents, depending on how far the mean characteristics for each sample are away from those for the post-period demonstration group. The variance of the post-period demonstration group will be the variance of the percent itself. If, instead, we consider explanatory values further from the mean, the minimum detectable amounts will increase. In such an analysis, we would essentially be applying the DID estimator to a subgroup, defined by the explanatory variables. To determine the minimum detectable impact, it is necessary only to determine the size of the relevant subgroup (e.g., women over age 80 with income below 100 percent of poverty) and look up the value in the table that corresponds to that size.

The numbers in *Exhibit 8.8* assume independence of the pre- and post-samples period, but we know this to be incorrect because many beneficiaries will be in both. The effect, though, is to reduce minimum detectable impacts because comparing outcomes for the same people eliminates pre- and post-variations in the unobserved characteristics of the samples. In the extreme, if all

sample beneficiaries were the same in the two periods, minimum detectable differences would be just 71 percent of those reported in the exhibit.<sup>43</sup>

We also propose to examine the robustness of the results to changes in the estimation methodology. As indicated above, there are many choices that must be made in selecting a final specification, and each of these can affect the findings. Choices include, but are not limited to, pooling, hazard versus month-by-month analysis, linear versus logistic models versus other binomial or hazard specifications, and specification of explanatory variables. When there is more than one feasible option, we will experiment with alternatives to assess the sensitivity of the results to our choice. In general, we will choose the simpler alternative unless we find that doing so will have a quantifiable impact on the results.

Qualitative assessment of the results will be important. The qualitative assessment will focus on factors that might produce bias in the DID estimates and variation in the estimates across the sites—most likely changes in other factors (e.g., use of self-declaration in the demonstration sites only in Florida) that might have differential effects on enrollments in the demonstration and comparison group areas.

## **B. Cost Analysis**

### **1. Overall Strategy**

The cost-based analysis will focus on the administrative cost to the government (federal, state, and local) of increasing participation in the Medicare Buy-in program through the efforts being tested in the demonstration. That is, we will estimate how much it will cost the government to generate an additional hypothetical applicant or successful applicant (e.g., the participant with the mean characteristics of all participants) under each of the four models being tested.

This analysis does not focus on the additional program cost related to payment of the Medicare Part B premium and cost sharing for the additional participants because the greater the success of the program, the higher these costs would be. We assume that SSA is interested in the cost-effectiveness of the outreach efforts because the goal is to increase participation. However, it will be possible to generate an estimate of additional program cost.

We also assume that the states and SSA will be able to provide appropriate administrative cost data. We would like to distinguish between start-up or demonstration costs, which are one-time costs and recurrent costs; the former can be amortized. Also, costs that are generated by the fact that this is a special demonstration (e.g., initial training and overtime), rather than a permanent program, will be deducted if feasible. Finally, we will calculate the costs of the outreach effort in increasing participation. We are not calculating the ongoing eligibility costs associated with managing these new cases. Although we will discuss these additional costs, we will not attempt to quantify them. In addition, while applying for Buy-in benefits, new enrollees might learn of new benefits for which they are eligible, such as food stamps. This analysis will not include the costs associated with these programs.

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<sup>43</sup> The factor is the inverse of the square root of two. This follows from the fact that the maximum variance for the DID estimator is halved.



Cost-effectiveness might depend on participants' characteristics because the estimated outcome effects might also depend on characteristics. We will analyze the relationship between cost-effectiveness and participant characteristics in the same fashion in which we have proposed to analyze the relationship between application probability and participant characteristics. That is, we will compute cost-effectiveness ratios for each participant, group participants by the computed ratios, produce descriptive statistics for each group, and examine how these differ. The analysis might find that the demonstration was cost effective for some types of participants but not for others. This type of information could be useful to policy makers.

In general, administrative costs to the SSA central office associated with taking one of the models nationwide will not be included. Although these costs could be substantial (e.g., the cost of developing an integrated, nationwide, computerized screening system), they are beyond the scope of the demonstration and cannot be measured accurately.

## **2. Definition of Costs**

We define costs of the Buy-in program as all expenditures made by the federal, state, and local governments required to operate the program. Costs can be divided into three categories: research-related, start-up, and operating.

### ***(a) Research-related costs***

Research-related costs are associated with evaluating the demonstration but not implementing it. These costs will be excluded from the analysis. For example, the time spent by The Lewin Group and SSA's Office of Research, Evaluation, and Statistics on the evaluation of the demonstration will not be included. In addition, we are assuming that time spent by SSA program staff developing the models, selecting the sites, drafting the Federal Register notice and developing the screening software program are research related.<sup>44</sup> In addition, time spent supplying SSA with data to analyze the demonstration (e.g., state Medicaid records; data from the screening program) and time spent meeting with The Lewin Group staff during site visits are considered research-related costs.

### ***(b) Start-up costs***

Start-up costs are the costs associated with initiating a new model. These include purchase of a new computer for the DSU center. They can also include time spent training staff on using the screening software. As mentioned above, they will not include program development time.

### ***(c) Operating costs***

Operating costs are all other costs associated with implementing the program, including the following:

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<sup>44</sup> An argument could be made for including or excluding the cost of developing a nationwide screener tool. The electronic screener provides a uniform method for determining potential eligibility that could be used in and modified for a national program. However, the purpose of some questions in the screener is primarily to gather data for demonstration-related analyses. We will present an estimate of the cost to fully integrate the screener into the SSA system and scheduler.

- Field office staff time spent on the Buy-in demonstration
- Local Medicaid staff time spent on the demonstration
- DSU staff time
- Office space
- Equipment
- Telephone
- Utilities and other overhead
- Postage and printing

Some resources used by the demonstration are shared with other programs. For example, the screening software program was installed on existing computers used for other functions in the field offices. In such situations, we will allocate a portion of the costs to the demonstration, based on an estimate of the time or use devoted to the Buy-in program. Also, we will allocate a percentage of the office space costs to the demonstration.

### **3. Time Frame**

As noted above, we plan to calculate the cost of enrolling individuals in the Buy-in program excluding ongoing case management costs. Therefore, we need to select a time frame for the cost analysis that captures the outreach efforts, the time spent screening individuals, and the time spent enrolling individuals, but not time spent conducting redeterminations. This time frame will vary by model because the mailing dates vary by model. As mentioned in Chapter 5, the screening model mailings occurred between March 7, 1999, and June 7, 1999; the co-location model mailings occurred between April 8 and July 22; and the application model mailings occurred between April 23, 1999, and August 9, 1999. If we assume that individuals will begin enrolling as a result of the model approximately one month after the first mailing and will continue up to three months after the last mailing, the time frame for analysis by model is as follows (see *Exhibit 8.9*):

- Screening model: April to September
- Co-location model: May to October
- Application model: June to November

**Exhibit 8.9****Relevant Months for Analysis, by Model**

		Mar-99	Apr-99	May-99	Jun-99	Jul-99	Aug-99	Sep-99	Oct-99	Nov-99	Dec-99
Screening	Mailing										
	Applications										
Co-location	Mailing										
	Applications										
Application	Mailing										
	Applications										
Widow(er)s	Start-Up										
	Applications										

We have allotted up to three months past the last mailing date because states need time to process all of the applications generated by the demonstration. Three months should be sufficient. The enrollment information will come from the state data files, restricted to those associated with the demonstration (i.e., those who were screened). Start-up costs incurred earlier and that we think are relevant can be amortized and spread across this period.

Massachusetts field offices began informing recent widow(er)s who contacted the office about the demonstration April 15, 1999. As discussed in Chapter 3, the model increased its outreach efforts in September, 1999. To capture the costs and subsequent effect of the increased outreach, we will collect cost and enrollment information through December, 1999.

#### **4. Costs per Applicant and Enrollee**

For each site, we will divide expenditures for the time frame into state costs and SSA costs. We will use the number of applicants and enrollees as the denominator for both equations. We will calculate the following cost estimates:

- State cost per applicant
- SSA cost per applicant
- State cost per enrollee
- SSA cost per enrollee
- Total cost per applicant (state + SSA)
- Total cost per enrollee (state + SSA)

Information on salaries, overhead, and direct costs of the demonstration (e.g., costs of postage, brochures, and posters) will be collected from SSA and state Medicaid offices. Time spent on demonstration activities will be estimated from interviews.

#### **5. Gross Costs versus Net Costs**

The gross cost is the cost per enrollee calculated above. The net cost is the cost above what would have been spent in the absence of the program. Doing this analysis accurately depends on obtaining reliable data for the comparison sites for the same time period. The net cost will be the difference between the total cost per enrollee for the demonstration site and the total cost per enrollee for the comparison site.